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Psychotherapy Dropouts View Their Treatment: A Followup Study

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PSYCHOTHERAPY DROPOUTS VIEW THEIR TREATMENT: A FOLLOWUP STUDY

by

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VITA

The author, Linda Joy Papach-Goodsitt, was born August 7, 1948 in South Bend, Indiana. She is the second of five children of Dorothy (Stilipec) Papach and Edward Papach. She is married to Alan Goodsitt, M.D., and they have one child, Daniel Jeremy.

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CHAPTER I

INTRODUCTION

Individual psychotherapy is one of the most commonly assigned modes of treatment at outpatient mental health facilities, and dropping out of this treatment is considered a serious problem in its practice and in mental health care policy. There are three major problems with professional use of the term dropout, however. One problem concerns the tendency of professionals to rely exclusively upon temporal criteria to operationally define dropout, in spite of the fact that the term connotes both a brief length of stay and therapeutic failure. A second problem concerns the tendency of professionals to rely exclusively upon their own perspective and values when evaluating the effects of treatment with short-term therapy clients, without benefit or representation of the client's own view. The third problem concerns the negative impact of dropout incidence statistics upon the practice, policy, and funding of mental health care service in the absence of empirical evidence that warrants negative interpretation.

The validity of the assumption of failure with psychotherapy dropouts was the key focus of the present work. By explicitly evaluating the outcome of clients at termination, short-term clients who had not improved were differentiated from clients who had made clinical gains

during their brief contact. A comprehensive picture of the effects of psychotherapy with short-term clients was offered by soliciting client evaluations of treatment in addition to professional evaluations. Furthermore knowledge about the phenomena of dropping out of treatment was expanded by evaluating psychotherapy dropouts several years post-treatment in terms of client self reported treatment experience, benefit, and effect, as well as level of functioning at followup and clinical history following termination.

Clients who had short lengths of stay and who were professionally judged at termination to have not improved were classified as psychotherapy dropouts. These clients were then compared to all other former psychotherapy clients to see whether or not dropouts were uniquely different from others in terms of treatment failure.

CHAPTER II

REVIEW OF THE LITERATURE

This literature review has eight sections. The author's purpose in this review is to present the major problems associated with professional use of the term psychotherapy dropout. It also aims to develop the thesis that more information is needed from psychotherapy dropouts themselves about why they dropped out of treatment, what their psychological condition was at the time of termination, and their post-treatment functioning and clinical history.

The criterion problem in the classification of psychotherapy dropouts is the focus of the first three sections. The first section discusses the temporal criterion used to classify dropouts in clinical practice and research. In the second section, the assumption of treatment failure attendant to this temporal criterion is discussed. The third section identifies the criterion problem in dropout classification as a failure to empirically validate this professional assumption of failure. The role of psychotherapeutic outcome evaluation is discussed in this section both in terms of offering a solution to the criterion problem and in terms of challenging professional prerogative in judgments of treatment outcome of psychotherapy dropouts.

Issues and research involved in the evaluation of treatment by psychotherapy dropouts themselves are reviewed in the next three sections. The fourth section focuses on the uniqueness and validity of client evaluations of treatment, with an emphasis upon the critical contribution to be made by dropouts themselves in the therapy evaluation process. The fifth section discusses research issues attendant to self reported evaluations of therapy experience and outcome, and the sixth section reviews the philosophical, methodological, and ethical issues involved in psychotherapy followup investigations.

The seventh section provides a summary of this review, and the final section states the purpose of the present study and its focal points of inquiry.

The Traditional Length Of Stay Definition Of Dropout

For all its complexity, individual psychotherapy can most simply be described as an interpersonal process that minimally requires the presence of its participants -- namely, a client and a therapist. If a client decides to stop participating in this process, and does so before the therapist believes there has been a sufficient trial of treatment, the client is labelled a psychotherapy dropout.

There are no definitive criteria for determining who is and is not a psychotherapy dropout, however, because the length of time necessary for a minimally sufficient course of treatment has never been and perhaps cannot be quantified. In the absence of definitional explicitness, most professionals have deferred to traditional beliefs about length of stay and improvement in therapy for dropout classification.

Professional Beliefs About Length Of Stay And Improvement

It is traditionally believed that a certain amount of contact with the therapist is necessary for a client to benefit from treatment. This belief is based upon the rationale that amount of contact directly influences the number of therapist opportunities to intervene with the client and, therefore, the number of client opportunities to be positively influenced by the intervention process. Although the exact amount of contact necessary for benefit to take place has never been quantified or standardized, it generally is believed that the longer a client remains in therapy, the greater the likelihood of improvement. Traditional beliefs about length of stay and improvement have been discussed by Garfield (1978).

Given these traditional beliefs, the shorter the length of a particular client's treatment, the more likely will the client be presumed a psychotherapy dropout. The practice of classifying dropouts on a temporal basis alone has been supported by research that shows brief therapies as frequently unilaterally terminated by clients (i.e., initiated by clients and against therapist advice and/or without therapist notification). In a study by Gabby and Leavitt (1970), for example, 45% of 400 clinic outpatients were seen for less than five sessions, and the majority of these clients were reported as simply discontinuing treatment on their own. Baekeland and Lundwall (1975), in their review of the dropout literature, similarly reported that four out of five clients who attended no more than four sessions of individual psychotherapy dropped out of treatment on their own.

Research and Clinical Applications Of The Temporal Definition

The research community has relied primarily upon a temporal definition of dropout. For example, a common methodological approach to investigating dropout phenomena has been to dichotomize client populations into two groups based upon length of stay. The shorter stay groups are designated dropouts, and the longer stay groups are labelled continuers or remainers. Another common methodological approach has been to treat length of stay as a continuous variable with factors related to short length of stay being interpreted as related to dropping out of treatment. This reliance upon the temporal definition in research reflects the dominance of the professional belief that longer rather than shorter lengths of stay are necessary to provide a sufficient amount of contact between client and therapist.

In clinical practice, the client who stays in therapy for a shorter versus longer period of time is more likely to be labelled a dropout. Clinical investigations into the actual length of time clients remain in psychotherapy have therefore led to the conclusion that a large percentage of the adult clientele at outpatient mental health facilities drop out of treatment. Fiester and Rudestam (1975), for example, reviewed the records of three urban mental health centers and reported that 37-41% of adult outpatients terminated their psychotherapies after the first or second visit. In an annual statistical report for psychiatric clinics in the states of New York and Maryland, Gordon (1965) reported that the majority of clients were seen for less than

five sessions. In a review by Baekeland and Lundwall (1975) 20-57% of clients at general psychiatric clinics were reported as failing to return for a scheduled appointment after their first visit, and 31-56% of the clients attended no more than four sessions. In two major reviews of length of stay in psychotherapy, Garfield (1971, 1978) summarized that, of clients who were offered and accepted psychotherapy, the median length of stay ranged from 3 to 12 visits wit a clustering around 6 sessions.

The dominance of the professional belief about length of stay and benefit from treatment is reflected in the broad application of the temporal definition of dropout to length of stay survey statistics, and has led Garfield (1978) and others to conclude: "It can be stated with confidence, therefore, that the finding of an unplanned and premature termination from psychotherapy on the part of many clients in traditional clinic settings has been a reasonably reliable one" (p. 197).

The Assumption Of Treatment Failure With Dropouts

When a client is labelled and classified a psychotherapy dropout, several assumption are made about the case. It is assumed that there has been a brief, insufficient trial of treatment. It is assumed that the client has unilaterally initiated the termination. And, most significantly, it is assumed that the client is a treatment failure.

Arguments That Support The Assumption Of Failure

The assumption that a failure occurs whenever a client drops out of treatment is common among today's professionals. The extent to which it permeates professional thinking is exemplified in Kelner's (1982) rationale for developing a dropout prediction measure. He refers to therapeutic efforts spent on dropouts as wasted time and energy from the therapist's and administrator's points of view as there are no obvious positive results from treating them. The assumption of failure can also be seen in Cartwright, Lloyd, and Wicklund's (1980) rationale for developing their screening device directed at identifying the "poor risk" dropout. They state how it has "long been recognized that not all those who apply for psychotherapy derive the help they came for before they withdraw from contact" (p. 263). The assumption is further exemplified in a statement by Heilbrun (1974) on what he considers to be an obvious fact about psychotherapy: "the client must be maintained in therapy long enough for constructive change to occur and that early defection denies the possibility of such change" (p. 42).

Some perspective on the professional's ready assumption of failure with dropouts can be gained by looking at what therapists regard as their role in psychotherapy. Therapists often see themselves as givers of insight, support, understanding, and/or new knowledge. They require time in which to make interventions that facilitate movement toward the professional value and goal of a more sound personality structure (Strupp & Hadley, 1977). When a client drops out of treatment, the time

and therefore opportunity for the therapist to do this work has been virtually eliminated. Clients may improve following their brief exposures to therapy as a function of environmental changes or raised expectations of help, hope, or cure (e.g., Gliedman, Nash, Imber, Stone, & Frank, 1958; Frank, 1961; Frank, Stone, & Nash, 1959; Rosenthal & Frank, 1956). Improvements as a result of these factors, however, pale in comparison to changes that the therapist was prepared to offer had the client actively engaged in a therapeutic process.

Therapists, in their work with dropouts, will inevitably be vulnerable to experiences of failure, devaluation, and rejection, as suggested by some research (Fiester, Mahrar, Grambra, & Ormiston, 1974; Johansson, Silverberg, & Lilly, 1980; Littlepage, Kosloski, Schnelle, McNees, & Gendrick, 1976), as long as the assumption of lengthier treatments is maintained as a necessary condition for desirable change. Perhaps this sense of failure and rejection explains why professionals assume the treatment outcomes of dropouts to be unfavorable.

Implications Associated With The Assumption Of Failure

The assumption of treatment failure with dropouts has broad professional implications. For example, mental health professionals tend to believe that dropouts remain in psychological need even though they have stopped their treatments. They believe that these clients have gained nothing from the therapy that they did have and have rejected treatment as a means to solve problems. Dropouts are not expected to seek treatment elsewhere, nor are they expected to return for treatment

should their circumstances change. Furthermore, it is generally believed that the clinical effort expended upon dropouts was inadequate, ineffective, and a waste of limited professional resources.

Within the context of these implications, clients have been charged with inadequate motivation for treatment, as well as with faulty personality traits that do not allow them to make commitments to a full course of treatment. Therapists have been charged with inexperience and countertransference problems that interfere with the requisite establishment of a positive relationship. Individual psychotherapy as a mode of treatment has also been charged with being indiscriminately offered to any and all clientele, disregarding the need for therapies specially tailored to certain disadvantaged populations, like the poor and the uneducated.

Arguments That Challenge The Assumption Of Failure

It seems reasonable to assume that some clients who drop out of psychotherapy fit the traditional description of failure mentioned above. It does not seem reasonable to assume that this description is accurate for all psychotherapy dropouts. What about clients who feel ready to try it on their own, even though their therapists think they should continue? What about clients who, after brief exposure to therapy, are symptom-free due to placebo effects inherent in the treatment situation? What about clients who return to a psychological equilibrium when the environmental stressors responsible for precipitating their symptoms diminish? What about clients who are unable to arrange for

financing, transportation, babysitting, etc.? What about clients who obtain relief from indigenous helpers in their communities and therefore turn away from therapy?

All too often, client terminations for any of the above reasons, that are initiated relatively early in the treatment process, are considered by the therapist or clinic to be suspect, premature, and/or not in the best interests of the client. As such, clients are ipso facto labelled psychotherapy dropouts and presumed to be treatment casualties. Little to no room is left for disagreement between client and therapist or clinic about when and/or why to terminate.

Fiester and Rudestam (1975) have referred to this blanket assumption of failure as the uniformity myth (Kiesler, 1971) of the psychotherapy dropout. They argue that not all dropouts are the same. Results from their studies have shown that dropping out of treatment does take place for reasons other than treatment failure. Baekeland and Lundwall (1975) have also argued that clients "not only drop out of treatment for different reasons and at different times but also that they are different kinds of people with different eventual outcomes" (p. 740). Papach-Goodsitt (1981) has argued that the application of the label psychotherapy dropout to all clients who initiate terminations early in their therapy is a misnomer. Because this label connotes therapeutic failure, she argues that it should be reserved for clients who in fact have not clinically benefited during their minimal treatment contact.

Empirical Evidence That Challenges The Assumption Of Failure

Garfield (1978) has noted that there have been few studies designed to systematically evaluate in detail the outcomes of psychotherapy dropouts. It is more common to find studies reporting on treatment outcomes of dropouts as an adjunct to their primary research goal. Nevertheless, empirical evidence to challenge the professional assumption of failure with these clients is accumulating.

Outcome studies of dropouts at termination and at followup. In one of the earliest studies reporting on the outcome of psychotherapy dropouts, Rosenthal and Frank (1958) found that one in three patients who stopped treatment on their own were judged improved at termination. Papach-Goodsitt (1981) reported that 35% of patients who terminated their treatments after 12 or less sessions had positive outcomes at termination as judged from their therapists' treatment summaries and closing notes. May (1984) reported that clients in community mental health settings terminate treatment feeling clinically improved at a variety of treatment lengths, ranging from 2 to 24 sessions.

A few studies have reported on the dropout's level of satisfaction with treatment received. In a telephone survey of early terminators by Littlepage, et al. (1976), little difference in treatment satisfaction was found between clients who terminated on their own and those who terminated with the consent of their therapists. Silverman and Beech (1979) telephone surveyed clients who attended only one session at a community mental health outpatient center. They reported that 79% of

the clients were satisfied with the treatment they received and 79% said their problems were solved.

Fiester and Rudestam (1975) conducted two separate studies on psychotherapy dropouts. One was at a state-supported mental health outpatient clinic and the other was at a hospital-based community mental health center. Some dropouts were found to be dissatisfied with the treatment they received, but others terminated because they felt they were ready to try it on their own, even when their therapists did not agree.

Gorkin (1978) reported that of clients who either dropped out of therapy or never came in for their first appointment at a psychoanalytic outpatient clinic, 32% said they felt better after their minimal contact with the clinic. Studies by Heineman and Yudin (1974) and Kline, Adrian, and Spevak (1974) reported that 50% of the dropouts in their samples were satisfied with treatment. Larsen, Attkisson, Hargreaves, and Nguyen (1979) also reported the surprising finding of a negative correlation between dropping out of treatment and dissatisfaction with treatment.

There have been a few followup reports on psychotherapy dropouts. Garfield (1963) found that, in comparing 12 dropouts with 12 remainers, both groups stated they were getting along well. Straker, Devenloo, and Mall (1967) conducted a two-year followup study of psychotherapy and found that 17.1% of the dropouts in their sample were doing well. Of the clients who dropped out after having at least 11 sessions, 72.7%

reported themselves as symptom-free. Of clients who dropped out before 11 sessions, 50% self reported successful outcomes.

Also, in a six-month followup of dropouts, Johansson, et al., (1980) found that clients who terminated with the consent of their therapists had significantly lower symptomatic disturbance than those who had unilaterally terminated (dropped out). There were no significant differences between the two groups on global improvement ratings however. Furthermore, while the therapists felt dissatisfied with the outcomes of clients who dropped out, the clients in general reported being highly satisfied with the treatment.

The results of these few studies indicate that from both therapist and client perspectives a relatively significant number of psychotherapy dropouts show some clinical improvement and experience a sense of well-being following their brief therapies, not to mention reasonably high levels of satisfaction with treatment received.

Spontaneous remission studies and control group outcomes. In a related line of research, findings from psychotherapy outcome studies dealing with spontaneous remission and wait-list or untreated control groups also support the idea that limited contact can have positive effects. In the Temple University psychotherapy project, Sloane, Staples, Cristol, Yorkston, and Whipple (1975) reported how their minimal treatment wait-list group, having received 5-1/2 hours of clinical interviewing at the beginning of the study, reported feeling helped following this contact. Forty-eight percent of these clients were rated as improved by an independent assessor at followup.

In the Tavistock Clinic psychotherapy study, Malan (1976a, 1976b) reported similar findings. A number of untreated control subjects reported feeling helped after a single assessment interview and, at the five- to six-year followup point, 33-50% of these subjects were rated as improved in their capacity to cope with stress, and 60-70% of them were rated as improved symptomatically.

Lambert (1976) in his review of the spontaneous remission literature has noted the benefit that is received by no-treatment controls after just one clinical interview or testing session. Voth and Orth (1973) of the Menninger psychotherapy project have also proposed that symptomatic relief in untreated clients can result if either the client is able to change the environment or the environment changes independent of the client's actions in such a way that conflict triggers are removed.

Psychotherapy dropouts cannot be equated with untreated control subjects for the circumstances surrounding their minimal treatments are quite different (American Psychiatric Association Commission on Psychotherapies, 1982; Gottman & Markman, 1978). Nevertheless, findings from the abovementioned studies do counter the traditional belief that more rather than less contact between client and therapist is a necessary condition for positive change.

The value of symptomatic relief. Frank (1961) has noted that symptomatic relief is not a highly valued professional goal of treatment given the professional belief that relief from symptoms is superficial

and transient. As discussed by Rosen and Proctor (1981), it is traditionally believed that "changes in internal personality constructs are necessary and/or sufficient for attaining desired change in other types of client behaviors" (p. 424).

In contrast to traditional belief, research at the Henry Phipps Psychiatric Clinic (Frank, 1959) found relief from symptomatic discomfort to have lasted over a five-year followup period. Psychodynamically, this can be explained by understanding that relief from anxiety and depression can free a client to utilize healthy parts of the personality which enables more effective personality functioning in general with related increases in self-esteem (Frank, 1961).

These studies also found that symptomatic relief did not ordinarily depend upon the nature or length of treatment, but seemed to occur quite promptly -- at the first contact between client and therapist. As such, Frank (1961) has proposed that the mobilization of a client's expectation of help can account for at least some of the success seen in psychotherapy.

Very minimal contact or just the anticipation of forthcoming help can provide a type of relief that not only immediately benefits the client, but can prove beneficial over the long run. Given that treatment failure with dropouts is assumed on the basis of short length of stay, these findings challenge the belief that dropouts receive no benefit from brief contact. What, if any, role expectation of help plays in the treatment outcomes of dropouts remains to be determined, however.

The Role Of Outcome Evaluation In The Classification Of Dropouts Refining Professional Use Of The Term Dropout

The classification of a client as a psychotherapy dropout is traditionally based upon the length of time a client remains in psychotherapy. But the label dropout goes beyond this temporal definition to imply that the client is a psychotherapeutic failure. Research has shown that this is not necessarily an accurate description of the outcome of every short-term case given the label dropout. Yet the distinction between dropouts that fit the traditional description of failure and those that do not does not tend to be made in clinical practice or in research methodology.

Dropouts who have received some benefit from treatment may peak professional interests but they do not draw the serious concern given to dropouts who have completely failed to obtain help. It is the dropout who early in treatment appears to reject psychotherapy as a means to solve problems, yet remains in psychological need, that is of target concern to mental health professionals. Clinically, these are the clients who are thought to be suffering, yet unreachable, through existing conventional treatment approaches. Administratively, these are the clients who are thought of as straining and wasting limited professional resources because of their inability or refusal to utilize psychotherapy as it is traditionally conceptualized and offered. And politically, federal, state, and local sources question the continued funding of psychotherapy programs and clinics when these clients account for a large percentage of their clientele.

The role of outcome evaluation in dropout classification can be one of empirically validating the mental health professional's assumption of therapeutic failure with dropouts. Empirical validation would replace implicit assumption with explicit judgment and in so doing make the necessary differentiation between clients whose needs were met through brief psychotherapeutic contact and clients who were unable or unwilling to obtain help through therapy but, in the professional's opinion, remained in psychological need.

A revision in the operational definition of dropout needs to be made in clinical practice and in research. In the interests of aligning what is traditionally meant or implied by the term dropout with its operational definition, it is recommended that the criterion of negative therapeutic outcome be added to the commonly accepted short length of stay criterion.

Questioning Professional Prerogative In Treatment Judgments Of Dropouts

The explicit consideration of outcome for psychotherapy dropouts introduces the complex field of psychotherapeutic outcome evaluation to this area of research. Criteria by which to evaluate therapy outcomes must be selected as well as operationally defined. These tasks are subject to a host of controversial value decisions that directly determine the type of outcome data collected and the nature of the results and conclusions drawn from that data (e.g., Howard & Orlinsky, 1972; Lambert, Bergin, & Collins, 1977; Strupp & Hadley, 1977).

For example, whose goals should be used as a baseline for therapeutic change -- the therapist's or the client's? What does it mean if the therapist and client differ about the goals to be achieved in therapy? What does it mean if the therapist and client differ about the amount of improvement to be achieved before termination, the amount of improvement to be satisfied with, or the reasons to terminate treatment? Who and/or what should be the focus of evaluation? The person of the client and his/her subjective sense of well-being in the world? The pathology of the client as reflected in objectively rateable symptomatology? The person of the therapist and his/her capacity to communicate feelings of acceptance, caring, interest, or wisdom to the client? The skill of the therapist as reflected in his/her ability to make accurate and well-timed interventions? Or the therapy itself as a process designed to make a beneficial difference in the lives of the people who partake in it? Who should evaluate the amount of change that does take place? The client, the therapist, or an independent third party? Finally, when should this evaluation take place? During the process of therapy, at termination, or at followup?

Prior to the inclusion of the outcome criterion, the definition of dropout was based solely upon professional judgment of the adequacy of the length of treatment with its corresponding assumption of failure for clients who utilized therapy in unconventional ways. As such, professional opinion was deferred to as the sole arbiter of a client's effective and meaningful use of therapy. The field of outcome research, how-

ever, recognizes professional judgment as but one of several valid perspectives from which to evaluate therapy (Strupp & Hadley, 1977), and current thinking in outcome evaluation recommends that the views of, at least, the client and the professional be included for a complete understanding of the impact of therapy in any given case (e.g., Attkisson, Brown, & Hargreaves, 1978; Larsen, et al., 1979; Lebow, 1982; Strupp & Hadley, 1977; Waskow & Parloff, 1975).

The role of outcome evaluation in dropout classification is not simply one that refines and clarifies professional use of the term. It has the inherent potential to challenge the tradition of relying solely upon professional standards and values as a basis for determining whether or not psychotherapy dropouts utilize treatment appropriately, effectively, and meaningfully.

The Uniqueness And Validity Of The Client's View Of Outcome

Inasmuch as practical application does not keep pace with contemporary thought, studies of psychotherapy outcome in general, and outcome studies of dropouts in particular, do not tend to include evaluations from the client's perspective. The perspective of the professional is most frequently utilized in psychotherapy outcome research.

In the interests of establishing the need for client evaluations in dropout research, several lines of argument are presented. First, professional recognition of the client's view of outcome, as distinct from and validly equal to professional opinion, is established. Second, the impact of the consumer movement on professional and public accep-

tance of client evaluations is discussed. Third, the clinical issues and empirical research related to evaluations of outcome by psychotherapy dropouts themselves is reviewed.

Professional Recognition Of The Client's View Of Outcome

The traditionally accepted criteria for evaluating psychotherapy has been in terms of a reduction in the manifestation of pathology in the client (Howard & Orlinsky, 1972). In keeping with this tradition, frequently employed and recommended measures of outcome, as detailed by Waskow and Parloff (1975), have included instruments such as the Minnesota Multiphasic Personality Inventory (Dahlstrom, Welsh, & Dahlstrom, 1972), the Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), Target Complaints (Battle, Imbert, Hoehn-Saric, Stone, Nash, & Frank, 1966), the Psychiatric Status Schedule -- Symptom and Role Scales (Spitzer, Endicott, Fleiss, & Cohen (1970), the Katz Adjustment Scales (Katz & Lyerly, 1963), and the Personal Adjustment and Role Skills Scales (Ellsworth, 1975).

More recently the concept that different yet equally valid criteria may be used to evaluate the same psychotherapy has been advanced. For example, Howard and Orlinsky (1972) state: "It is quite conceivable that, in any particular case, psychotherapy may have positive effects by some, negative effects by others, and negligible effects with reference to yet other value criteria" (p. 650).

In a key paper on the issue of alternate views in psychotherapy evaluation, Strupp and Hadley (1977) introduced the tripartite model of

mental health and psychotherapeutic outcome evaluation. The perspectives of the client, the mental health professional, and society were identified as three different vantage points from which to define mental health and judge therapy outcome. The values and standards of these three perspectives were also determined to be uniquely distinct from each other and to have equally valid criteria for outcome evaluation.

To briefly summarize, from the client's point of view, therapy would be a success to the extent that a sense of well-being in the world, self esteem, and self acceptance were achieved by the client. The mental health professional, on the other hand, measures therapeutic success according to the theoretical principles of a sound personality structure. This would be characterized by a lessening or absence of initial presenting symptomology as well as by improvements in important areas of the client's life, such as interpersonal relations, resistance to stress, and ability to cope with reality. The previously mentioned traditional means of evaluating therapy by the reduction or absence of the pathological condition in the client would be subsumed under this perspective. From a societal point of view, therapy success would be based upon the extent to which an individual responsibly assumed his/her assigned social role, conformed to prevailing mores, and met situational requirements. Strupp and Hadley (1977) concluded by stating that ideally the complete understanding of outcome for any given case would include evaluations from each perspective.

The significance of the tripartite model of mental health and therapy evaluation is that it establishes a scientific rationale for the concept that alternate views of outcome are equally valid, uniquely different, and methodologically essential for understanding the results of psychotherapy. The tripartite model also offers professionals a new way of understanding, and perhaps resolving, a long standing problem in outcome research. That is, the problematic finding that there is an overall lack of agreement between studies of outcome when different raters and different outcome measures are used, as well as within studies when the same outcome instrument is used by different raters.

The conventional interpretation of this lack of agreement has focused on measurement error, with a heavy emphasis upon fallability in the form of rater bias (e.g., Cartwright, Kirtner, & Fiske, 1963; Garfield, Prager, & Bergin, 1971; Mintz, Auerbach, Luborsky, & Johnson, 1973; Meltzoff & Kornreich, 1970). In contrast to measurement error, however, Paul (1976) has suggested that differences in ratings could be because people in different roles use different frames of reference for making overall judgments of success or improvement. Strupp (1978) has similarly concluded that the low to moderate correlations between outcome ratings by patients, therapists, and independent raters could indicate legitimate differences in perspectives between the raters, as opposed to rater bias.

The most current thinking on outcome research reflects the concept of the tripartite model of evaluation. It is now highly recommended

that the perspectives of at least the client and the professional be included in outcome evaluation for a more complete understanding of the results of psychotherapy (Attkisson, et al., 1978; Larsen, et al., 1979; Lebow, 1982; Strupp & Hadley, 1977; Waskow & Parloff, 1975).

The Impact Of The Consumer Movement

The consumer movement of the last fifteen to twenty years has played an important role in professional and public acceptance of client evaluations of psychotherapy. In 1964, Strupp, Wallach, and Wogan (1964) noted that from a scientific standpoint psychotherapy clients may not be the final judges of therapy outcome, but "practically speaking, they are the 'consumers,' and their voices inevitably will be heard" (p. 47). By 1982, a number of articles have appeared emphasizing the rights of clients as consumers of the product of therapy to evaluate their treatments (e.g., Larsen, et al., 1979; Lebow, 1982; Morrison, 1979).

The consumer movement has not only touted the rights of clients to evaluate therapy, but has advanced the consumer approach as essential to improving utilization of therapy and its effectiveness (Kaufmann, Sorenson, & Reaburn, 1979; Kazdin & Wilson, 1978; Larsen, et al., 1979; Lebow, 1982; Morrison, 1979; Schainblatt, 1980), preventing consumer fraud (Flynn, Balch, Lewis, & Katz, 1981; Morrison, 1979), and safeguarding against the provision of too little service or service of poor quality (Marvit & Beck, as cited in Larsen, et al., 1979; LeVois, Nguyen, & Attkisson, 1981; Margolis, Sorensen, & Calano, 1977).

These arguments have been taken seriously by the federal government, hospital accreditation boards, and client/citizen mental health review boards, for client satisfaction criteria are currently used to assure quality and relevance of mental health programs for clinic populations (Flynn, et al., 1981; Larsen, et al., 1979).

Further, public acceptance of the client's role in program evaluation has forced the mental health professional to consider, if not the uniqueness and value of the client's perspective, at least the increasing impact of this perspective upon utilization and funding of their therapy programs. As such, professionals must expand their evaluation efforts to include measures that not only tap their own judgments but the judgments of their clients.

Clinical Issues And Research In Outcome Evaluations By Dropouts

The definition and classification of a client as a dropout is a practice performed by professionals and based upon professional standards and values. For example, up until now short-term therapy clients have been given the label dropout and assumed to be therapeutic failures because lengthier stays in therapy were considered necessary to effect improvements -- improvements that were valued by mental health professionals. The addition of a negative outcome criterion to the temporal definition of dropout further ties classification of dropout to professional standards and values as outcome is traditionally evaluated from the perspective of the professional.

This tendency of professionals to view psychotherapy through their eyes only has been challenged by contemporary thought in the field of outcome evaluation. The spirit and significance of this challenge is particularly critical in dropout classification and research, as is evident in a statement by Meltzoff and Kornreich (1970) who suggest that the therapist's designation of a client as a dropout may be more indicative of a disagreement between client and therapist about the goals to be achieved in treatment, than an accurate statement about whether or not any actual client change took place. It is also evident in a discussion by Baekeland and Lundwall (1975) who cogently argue that while symptom relief and/or support may not be the goals of treatment from the therapist's point of view, from the client's viewpoint they may have terminated treatment because they got from therapy what they wanted in the first place.

An appreciation of the potential for discrepancy between the professional and client views is critical in dropout research, as is suggested by the results of a few research studies in which professional classification of a client as a dropout was found to be problematic from the point of view of the therapist, but not necessarily from the client's point of view.

For example, in their study of dropouts at a state-supported mental health clinic, Fiester and Rudestam (1975) found that early termination from psychotherapy took place for one of two general reasons. One was because clients were dissatisfied with therapy, and the

other was because clients were ready to try it on their own whether or not their therapists agreed. The finding that some dropouts terminated early but were satisfied with their treatments suggested to Fiester and Rudestam that sometimes dropping out of treatment is only a problem from the "rejected" therapist's perspective.

Littlepage, et al., (1976) conducted a telephone survey of outpatients at a mental health clinic and found no difference in treatment satisfaction between clients who terminated with notice versus without notice. There were also no differences between clients who had limited versus extended treatment contact. Based on these results, Littlepage, et al. (1976) hypothesized that early termination from therapy may only be a problem for therapists who prefer longer treatments, but not a problem for clients themselves.

In their six-month followup study at an outpatient mental health clinic, Johansson, et al. (1980) found that clients who mutually terminated therapy had significantly lower symptomatic disturbance at followup than clients who unilaterally terminated (dropped out). There were no differences between the two groups on two global improvement measures, however. Additionally, clients regardless of manner of termination were highly satisfied with treatment at followup, but therapists felt dissatisfied with the outcome of the unilateral terminators. These findings support the hypothesis that dropping out of treatment can be a problem for therapists but not necessarily for clients.

Results from other client satisfaction studies have supported this hypothesis. For example, Heineman and Yudin (1974) and Kline, Adrian, and Spevak (1974) reported that 50% of the dropouts in their samples were satisfied with the treatment they received. Larsen, et al. (1979) found a negative correlation, $\underline{r} = -.37$, between client dissatisfaction and premature termination. That is, clients who terminated early were more satisfied than clients who terminated later. In a review of the client satisfaction literature, Lebow (1982) concluded that while the relationship is statistically significant, there is considerable lack of overlap between client satisfaction and dropping out of treatment.

Meltzoff and Kornreich (1970) have asked the poignant question: "If terminators (dropouts) are considered to be patients who have ended treatment prematurely, by whose standards is the termination premature?" (p. 372). Professional judgment will determine whether or not short-term dropouts measure up to professional standards of improvement in psychotherapy. But evaluations based exclusively on professional criteria will not determine the judgments of the dropouts themselves and whether or not their own standards of need and satisfaction were measured up to in their brief therapeutic encounters.

The tendency to exclusively rely upon professional standards of length and improvement in therapy leaves therapists and their sense of value about the work that they do with dropouts acutely and perhaps too harshly vulnerable to experiences of failure with them. It is perhaps too harsh because alternate approaches to evaluation can offer profes-

sionals a way of understanding and experiencing their work with at least some dropouts in terms other than blanket failure, as suggested by client satisfaction research.

This exclusivity also fuels the alarm and concern with which many professionals, administrators, and politicians view the high rate of treatment dropout. Perhaps this view should be tempered with the understanding that some, if not many, of these clients utilize the little therapy that they accepted in their own way and to the satisfaction and benefit of their own needs.

With the exception of studies that primarily inquire about the client's global satisfaction with treatment, however, there have been no studies that have explored, from the dropout's point of view, their experience of the therapy that they did receive, their opinion of its effectiveness, and their evaluation of their own clinical status. Research in this area needs to be undertaken.

Research Issues In Self Report Methodology

It has been argued that dropouts can make a critical contribution to understanding the dropout phenomena by self reporting their experiences of therapy, their reasons for terminating treatment, and their opinions of therapy effectiveness. Self report methodology is a controversial approach to psychotherapeutic outcome evaluation, however. As such, a review of the issues involved in self report methodology is presented.

The Science/Art Dilemma

Differences in opinion invariably arise when raters of outcome make their necessary qualitative and quantitative judgments during the process of evaluation. In recent years a portion of the variance in outcome ratings has been reasonably explained by Strupp and Hadley (1977) and others as representing legitimate differences between the roles and perspectives of the people doing the ratings. But because differences tend to be the rule rather than the exception in outcome research, the research professional is presented with a dilemma. At issue on the one hand are the principles of science and the need to account for and control variance in measurement in order to assure reliability and validity. At issue on the other hand is a concern that strict adherance to traditional scientific criteria and methodology precludes understanding human endeavor in all its complexity.

Malan (1973) grapples with this dilemma in his review of the outcome problem in psychotherapy research and comments on the failure to design research criteria that do justice to the complexity of the human personality. Bergin and Suinn (1975) address this dilemma in their methodological critique of outcome research and discuss the need to design research that is "close to clinical phenomena while also providing objectivity and quantification not present in traditional case histories" (p. 524). Bergin and Lambert (1978) emphasize the importance of the phenomenological in contrast to the currently popular focus on overt behavioral criteria in outcome research. They comment on the need to

develop criteria that are sensitive to the interpersonal and nonspecific or nontechnical factors that influence patient improvement.

Hine, Werman, and Simpson (1982) have proposed the need for an alternate approach to human science research -- one that balances careful observation or experimentation with what has been termed the personal, subjective, and rhetorical. They base this proposal on the contemporary philosophy of science that posits all knowledge as fundamentally grounded in personal, subjectively derived beliefs that cannot be justified in physical, observational terms. They conclude that it is "more in our interest to use that tacit, subjective knowledge than ignore it in a futile quest for scientific certainty" (p. 206).

The Benefits Of Self Report

A number of researchers have applauded the use of client and therapist self-report as a methodological approach that values and capitalizes on subjective knowledge. Howard and Orlinsky (1972), for example, have noted that the client and therapist, by virtue of their participant status, can report on data that is simply not available to third-party, non-participant observers. Zax and Klein (1960) have similarly commented on how the client and therapist are in a more favored position to provide leads regarding what takes place in psychotherapy. Fox, Strupp, and Lessler (1968) have elaborated on this point, arguing that internal changes in feelings can be reported upon directly by clients and that these important changes have little to do with objective criteria utilized by independent raters.

Luborsky (1971) has detailed some of the advantages of client and therapist self reported outcome evaluations. For example, he notes how therapists and clients can make judgments of outcome based on their intimate knowledge of the specific areas that need to be changed in relation to areas that did change during psychotherapy. This contrasts with outcome judgments made on the basis of data one or several steps removed from the therapy experience, such as judgments based on outcome scales like the MMPI, ratings of pathology via tapes, or supervisor evaluations of therapeutic change.

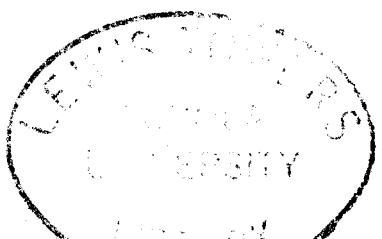
Luborsky (1971) also points out that clients and therapists know the worth of the change that takes place in therapy. As such, self reported evaluations can reflect the qualitative meaning and value of change and not be strictly limited to quantitative assessment as are evaluations from outside vantage points.

Luborsky (1971) further considers cases in which an initial symptom (urinary incontinence, for example) is present at termination but is no longer troublesome to the client. From a third-party and/or behavioral perspective, therapy in cases such as these would likely be judged ineffective. But from a first- or second-party perspective (client or therapist self report, respectively), knowledge and therefore consideration of subjectively experienced changes toward the self and the symptom may result in a qualitatively different judgment of outcome.

Criticisms Of Self Report

Researchers have argued against the use of self report for the very reason -- its subjectivity -- that others have argued for it. For example, Meltzoff and Kornreich (1970) have expressed the view that neither the client nor the therapist have sufficient objectivity to be able to adequately judge outcome in order to satisfy requirements for scientific study. Paul (1966) has described subjective reports of change by clients and therapists as "notorious" for their lack of reliability and validity. Imber (1975) has commented on how it is paradoxical to rely on clients to judge the quality and extent of their own feelings and behavior when by definition they are under high emotional stress that leaves their judgments open to criticism. Spitzer and Endicott (1975) believe that client self report should be limited to areas clients are capable of judging, such as mood, attitude, and obvious aspects of functioning. Schainblatt (1980) has raised the credulity problem caused by outcome judgments made by the very people (the therapists) whose services are being evaluated. Garfield, et al. (1971) and Scheirer (1978) have cautioned that both clients and therapists can have strong needs to justify their joint efforts and as such overestimate the benefits of their treatment.

In general, Fox, et al. (1968) have pointed out that American psychology is mistrustful of the subjective in favor of objective knowledge such as client work productivity, change in the quality of the client's interpersonal relationships, or change in symptomatology. On a theore-



tical level, Gottman and Markman (1978) have noted how Rogerian theory favors the subjective, but behavioral theory favors observation of behavior and analytic theory mistrusts the subjective as it is vulnerable to conscious censorship.

The concerns and objections to self report listed above quite naturally lead researchers to question whether or not clients and therapists, in their self reported evaluations, are responding to the straight content of the questions asked of them or to other features of the testing situation or factors associated specifically with self evaluation. Add to this healthy skepticism, however, a professional climate that in general does not welcome reliance upon subjective knowledge, and concerns such as those listed above can lead professionals to dismiss self evaluation altogether. Consider, for example, the statement made by Campbell (1969): "Human courtesy and gratitude being what it is, the most dependable means of assuring a favorable evaluation is to use voluntary testimonials from those who have had the treatment" (p. 426).

Improving The Self Report Method And Understanding Its Data

Supporters of self report evaluations frequently take the position that a thorough understanding of the method's problems and limitations is requisite to its use (e.g., Gottman & Markman, 1978; Lebow, 1982; LeVois, et al., 1981; Zax & Klein, 1966). The American Psychiatric Association (1982), Cartwright (1975), Lebow (1982), LeVois, et al. (1981), and Zax and Klein (1966), to name a few, have specifically addressed methodological problems inherent in the self report approach,

such as client response sets and styles (e.g., acquiescience set, social desireability, falsification, malingering), client desires to please the therapist, client concern for continued access to service, client unconscious distortion, client need to justify entry into therapy as well as termination from therapy, and therapist bias toward positive change as a measure of self worth. Lebow (1982) has elaborated upon many of the objections to and limitations of self report in his extensive review and support of client satisfaction research.

Work has also been done on reducing the likelihood of influence from these potential sources of bias. Approaching the client and therapist in such a way as to reduce tendencies toward personalization of the evaluation has been one recommendation. For example, Lebow (1982) and LeVois, et al. (1981) have suggested an approach to client and therapist that emphasizes anonymity, explains the intent to evaluate therapy as a service and not as individual therapy per se, offers reassurance about intent as necessary, and explains the use of group versus individual data analysis. The use of non-therapists as data gatherers was also recommended.

Other researchers (e.g., Cartwright, 1975; Strupp, 1975; Zax & Klein, 1966) have suggested that bias from these sources can be reduced by restricting the research sample to clients who have been out of therapy for awhile, and asking for their restrospective assessments of therapy. Retrospective assessment introduces the bias of memory distortion, however (Fiefel & Eells, 1963; Paul, 1976), but Cartwright (1975) has

suggested that this problem can be attenuated by orienting clients and therapists to a fixed period in order to enhance the recall process. Assessment at some point after termination also bears the distinct advantage of providing much needed information on client well-being and functioning at followup.

In addition to working toward understanding and controlling problematic biases in the method, researchers have also directed attention toward understanding the meaning of self report assessments. For example, Mintz (1972) reported that the pre-post ratings of therapy change by independent judges were a function of the judges' perceptions of client post-treatment status, regardless of initial disturbance level and/or the actual amount of change that took place. This same relationship held for client self ratings of change (Mintz, 1972) and for staff ratings of client improvement (Keniston, Boltax, & Almond, 1971).

On the basis of studies by Keniston, et al. (1971), Mintz (1972), and others, Green, Gleser, Stone, and Seifert (1975) have concluded that global improvement ratings by therapists and staff raters, as well as assessments of global symptom relief by clients, are made on the basis of client current level of functioning and degree of illness at the time of evaluation. This is in contrast to ratings made on the ostensible basis of actual change or improvement. Interestingly, Green, et al. (1975) have also reported that the major dimensions tapped by both tacit and explicit assessments of client final status are the client's general level of symptomatology, particularly in the areas of anxiety, depression, and somatic complaints.

The variable of client self reported satisfaction with treatment, recently reviewed by Lebow (1982) and Tanner (1981), has been found to be closely and positively related to client global assessment of the success of treatment. A low to moderate relationship has been found between premature termination and the client's view of specific changes resulting from treatment. A low correlation has been reported between client satisfaction and therapist assessment of change, and a low to moderate correlation has been found between therapist and client satisfaction with treatment, with clients being more satisfied than therapists.

Research on the dimensionality of the client satisfaction variable has reported mixed results. Four factor analytic studies, for example, found client satisfaction to be multidimensional. Brown (1979) reported seven factors (satisfaction with therapist, outcome, clinic service, felt importance, access, confidentiality, and therapist intent). Love, Caid, and Davis (1979) reported seven factors (satisfaction with overall care, staff responsiveness, staff behavior, center accountability, whether client needs were met, medications given, and ease of accessability to the clinic). Fiester and Fort (1978) found two factors (client satisfaction with outcome and accessibility), and Tessler (1975) reported two factors (satisfaction with problems solved and closeness with the therapist).

Other researchers (Frank, Salzman, & Fergus, 1977; Larsen, et al., 1979) have reported finding high interitem correlations within question-

naires administered to clients on the details of their experiences and satisfaction with therapy and the clinic setting. These results are consistent with the view that client satisfaction is a unidimensional variable.

An Argument In Support Of Self Report Evaluations

The use of client and therapist self report in psychotherapy research is one method of measurement that has the potential to balance our needs for quantification and observation with our fundamental personal realities. It is a method that openly and directly relies upon the subjective of the client and therapist to make judgments and provide information on both subjective and objective phenomena. In so doing, it is a method that provides a wealth of data that is individualized and close to the experience of psychotherapy that, at the same time, can be methodologically quantified for statistical analysis.

The American Psychiatric Association (1982) has concluded that the therapist is a valuable informant in the analysis of the complex data of clinical outcome and considers it a serious mistake to abandon therapist self report because of potential rater bias.

Concerning outcome evaluations by clients, the American Psychiatric Association (1982) has suggested that the general suspicion surrounding the validity of client self report may be unwarranted, noting "that the fact that biases connected with self report data may exist does not mean that they necessarily do exist in every case" (p. 63). Furthermore, the American Psychiatric Association (1982) has pointed out

that some biases may be of trivial magnitude and therefore have little impact on the nature of the data being collected. It was also pointed out that group data analysis often cancels out biases, given that opposite biases often occur within samples.

Acknowledgement of the method's limitations and its vulnerability to particular sources of bias has been judged essential to its use. Interpretations of research data based upon the self report method need to be made within the context of a depth understanding of the meaning and determinants of self report evaluations, of which face validity is one aspect. In addition measures need to be taken to reduce the likelihood of intrusions from bias.

In conclusion, from a philosophical stance that posits subjective knowledge as bedrock, client and therapist self reports provide unique and essential information that must not be dismissed. Fortunately, their high face validity has made them difficulty to ignore, even by Western scientific standards.

In specific defense of client self report, Strupp, et al. (1964) have pointed out that clients have as great a stake in developing more efficient techniques in psychotherapy as do therapists, researchers, and administrators, and can often aptly apply their energies toward this end. As persuasively argued by Fox, et al. (1968): "if we are prepared to believe the client initially when he says that he is disturbed and in need of help, then we should not discount his report after therapy that he is no longer disturbed or no longer in need of treatment" (p. 40).

Research Issues In Therapy Followup Evaluations

Meltzoff and Kornreich (1970) have asked a critical question: "What of the ultimate fate of patients who reject or prematurely leave therapy?" (p. 371). Professional expectation tends to hold that dropouts remain in psychological need, do not go on for treatment elsewhere, and do not return for treatment at a later time.

Whether or not dropouts are in fact the treatment casualties that mental health professionals assume them to be has yet to be put to an adequate empirical test. Baekeland and Lundwall (1975), for example, have pointed out in their review of the dropout literature that longer term followup studies have not been conducted on dropouts, and the few shorter term studies that have been done have not had adequate sample sizes. In addition, while there has been increased interest in following up dropouts in the client satisfaction literature, the satisfaction with treatment variable does not by itself provide enough information to judge the efficiency or effectiveness of psychotherapy contact with these clients.

A longer term followup investigation is necessary to establish the ultimate fate of psychotherapy dropouts. Information on the dropout's therapeutic experience, with special attention to reasons for termination, treatment outcome, and post-treatment functioning and clinical history needs to be gathered. It has previously been argued that this evaluation be a self reported one from the perspective of the dropout.

In the interests of understanding the meaning of psychotherapy followup data, the philosophical issues and methodological and ethical problems involved in followup research design will be discussed.

The Importance Of Timing In Outcome Evaluations

The traditional model of psychotherapy outcome evaluation, discussed by Howard and Orlinsky (1972), assumes that termination is the appropriate time to evaluate the effects of treatment and that followup is the appropriate time to assess the stability of those effects. These assumptions about when to assess therapeutic effects and their stability have been criticized by professionals on a number of grounds.

Regarding assessment at termination, concern has been expressed that this point in time may not provide an accurate picture of change that results from psychotherapy. For example, Luborsky, Singer, and Luborsky (1975) have pointed out that assessments at termination do not provide adequate opportunity for the effects of certain forms of treatment to emerge. Strupp, Fox, and Lessler (1969) have similarly critiqued evaluation at termination, commenting that consolidation of gains from psychotherapy can require considerable periods of time. In support of this notion they have cited research by Schjelderup (1955) which has suggested periods of up to four or five years as necessary for consolidation in some cases.

There is also concern that representative sampling of a client's mental, emotional, and behavioral functioning cannot be obtained at point of termination, for as discussed by Strupp, et al. (1969),

termination can be a period of upheaval, particularly in cases where intense transference relationships have been established. For clients who experience this upheaval, evaluation at this time would not present an accurate picture of their psychological gains resulting from treatment.

Assessment at point of termination has also been criticized because it does not provide information on the stability or longevity of treatment effects. This criticism, discussed by Howard and Orlinsky (1972), is based upon the traditional value that worthwhile and effective treatment effects are those that are stable and lasting. As such, some professionals (e.g., Morrison, 1979) take the position that the ultimate success or failure of psychotherapy can only be determined by assessments conducted at some point or points in time following termination.

Regarding assessment at followup, Frank (1968) has questioned judging the merits of psychotherapy by the maintenance of long-term effects. He has likened the value of stability of effect to the five-year cure rate in medicine and surgery, stating that a misunderstanding of what can be gained from psychological treatment may underly the application of this value to the field of psychotherapy.

How reasonable is it to use the concept of permanency -- that is, permanent reduction or alleviation of psychological distress -- as a yardstick of therapeutic success or failure? In the opinion of some professionals (e.g., Stone, Frank, Nash, & Imber, 1961) and some clients

and their families, a reduction in the duration of suffering, although relatively brief, can be sufficient justification for psychotherapy. This point is illustrated by Rosen (1969) in his clinical scenario of a patient with schizophrenia:

> From the standpoint of the individual patient, and his family, it is a blessing to be free of schizophrenia, even for a few months or a few years. To be free of it forever, is almost miraculous, and few therapists are miracle-workers, no matter what their treatment methods may be (p. 73).

When taking the position that reduction in the duration of suffering is a significant and sufficient goal of treatment, point of termination rather than followup would be the preferred time for evaluation with a focus on type and degree of effect, and not on its maintenance or stability.

Assessment at followup has also been criticized for the considerable expense of time and money involved in such investigations (Frank, 1969). This criticism is particularly strong for those investigators who believe that results at the end of therapy are relatively good predictors of followup status (e.g., Frank, 1969; Paul, 1967).

The timing of an evaluation can directly effect the nature of the outcome data obtained. This can be illustrated with the hypothetical case of the client with schizophrenia mentioned above. If assessment were to take place at termination, improvement would possibly be the outcome. But if some followup point were chosen as the time for evaluation, deterioration would probably be the picture. Which point of assessment provides for the truest accounting of the effects of treatment?

Some professionals have responded to the question of timing in outcome evaluation by reshaping it and the traditional model of psychotherapy outcome evaluation from which it comes (e.g., Gottman & Markman, 1978; Liberman, 1978; Stone, et al., 1961; Strupp & Bergin, 1969). They believe that it is not a question of the ultimate success or failure of therapy but a question of determining what the effects of a particular treatment actually are and how they compare with the effects of other possible treatment approaches, including no treatment approach, on factors such as degree, speed, and quality of improvement.

This philosophical approach to evaluation has been thoroughly discussed by Gottman and Markman (1978) who have concluded that it is inappropriate to apply Fisherian methodology, with its predetermined planting and harvesting times, to social systems research. They argue that interventions with social systems have effect patterns, not single effects. As such the task in psychotherapy evaluation is to investigate these patterns of effect. The value of an intervention, according to Gottman and Markman (1978), should be judged by whether it occurs immediately, is delayed, increases, decays, or is temporarily or constantly superior to other methods.

In conclusion, to select an assessment time with the intention of proving therapy's ultimate success or failure seems prematurely narrow in purpose and ill-fated as it presumes an appropriate time to evaluate the effects of treatment, and to date there is no professional consensus on this issue (American Psychiatric Association, 1982).

To select an assessment time with the intention of determining the nature and patterns of effect, however, circumvents the tendency to impose an artificial time frame for change on psychotherapeutic intervention. In the spirit of scientific inquiry, this approach seems to encourage exploration of the process of psychotherapeutic change, both in terms of its production and acceleration, and in terms of its maintenance (Liberman, 1978). It can provide information upon which to base an understanding of the potential benefits and limitations of various treatment forms in and of themselves. Finally, it can facilitate the making of comparative judgments of the effectiveness of different treatment forms in terms of quality, speed, degree, stability, and maintenance of improvements.

A Call For Followup Studies

The majority of psychotherapy and behavior therapy outcome studies have relied almost exclusively upon singular evaluations of treatment effects made at point of termination or at times shortly thereafter. For example, in a review of psychotherapy outcome studies, Luborsky, et al. (1975) reported that assessments of outcome made at times following point of termination were "either absent or too brief to catch the long-term benefits" of treatment (p. 1005). Cochrane and Sobol (1976) reviewed four major behavioral therapy journals and found that only 35% of the studies included followup assessments and of these only one-third had evaluations as much as six months post-treatment. Gottman and Markman (1978) similarly reported on outcome research on systematic desensi-

tization between the years 1970 and 1976 stating that only 25 of 55 studies had any followup at all. Of these, only six had retesting after periods of six months to one year, and six were reassessed after a one-year or greater period of time. Liberman (1978) has concluded in his discussion of long-term followup research that followup, when it occurs at all, is seldom for more than six months after the termination of treatment.

Recently, there has been a call in the literature to expand research design in outcome evaluation beyond the immediate effects of treatment (e.g., Bergin & Suinn, 1975). The rationales for recommending longer term and/or repeated measure followup studies vary. For some the intent is to make an ultimate statement of psychotherapy's effectiveness as it pertains to long-term maintenance of gains (e.g., Morrison, 1979). Others aim toward making comparative statements regarding the relative effectiveness of different forms of treatment (e.g., Stone, et al., 1961; Strupp & Bergin, 1969). The scientific exploration of the process of change has been of key concern to others (e.g., Gottman & Markman, 1978; Liberman, 1978), and basic curiosity has motivated others to ask the simple yet critical question: What happens to clients after they leave treatment (e.g., Schainblatt, 1980)? This latter question is particularly relevant when investigating clients who relapse or drop out of treatment (e.g., Gottman & Markman, 1978; Meltzoff & Kornreich, 1970).

Methodological Problems In Followup Research

The methodological problems attendant to followup research have no doubt deterred investigations in this area. Professional sentiment about these difficulties is reflected in a comment by Sargent (1960) who stated: "the importance of followup is equalled only by the magnitude of the methodological problems it presents" (p. 495).

Liberman (1978) has extensively discussed psychotherapy followup methodology and has categorized followup studies into two design groups. One is the global/archival design in which a global assessment of a client's present status relative to status at the end of treatment is usually made. The major methodological weakness of this design is the absence of a control or comparison group. Interpretation of results with this design is therefore limited to descriptive statements.

The second design is an intergroup comparison design in which two groups of clients, each receiving different forms of therapy, are assessed at termination as well as at future followup points. Unlike the global/archival design, inferential statements on the comparative efficacy of the treatments can be made.

There are three major methodological problems, discussed by Liberman (1978), that the two designs share in common, however. The first relates to how accurately the collected data represent the targeted population. Because client reasons for participation are not as compelling after therapy as during its course, participation in followup research is critically dependent upon the willingness of clients to volunteer time as well as their willingness to be reevaluated.

The second problem concerns the difficulty in obtaining a complete data set at the selected points of followup. Factors such as social mobility and transience, particularly in large urban centers, increase client attrition from the research sample, and this attrition increases over time. With regard to this point, Liberman (1978) has found that with the passage of five years contact is maintained with approximately 50-60% of the original sample. The difficulty of completing the original data set is also increased given that the ethical mandates of client confidentiality preclude tracing former clients through friends, associates, or family without prior consent from the client.

The third major methodological problem concerns the confounding effect of intercurrent events, such as divorce, death, marriage, birth, and job changes, that occur in the interval between the end of treatment and the followup assessment points. In a study of extratherapeutic environmental events, Voth and Orth (1973) concluded that these events would have a significant effect on the measured improvement at followup. Liberman (1978) has countered this interpretation, however, stating that other studies have shown intercurrent changes as uncorrelated with client followup outcomes. He also referred to the fact that overall clients tend to show improvement after a two- to three-year period. This suggested to him that factors other than intercurrent events are more influential in effecting improvement at followup.

Ethical Issues In Followup Research

In addition to unique methodological problems, the nature of psychotherapy followup research raises specific ethical issues. Because clients who either have been or are in crisis are being asked for their participation, there is an increased potential for coercion. To reduce the likelihood of coercion effects, therefore, special efforts must be made during followup data collection to ensure client confidentiality and free access to treatment regardless of the decision to participate.

The client's capacity to soundly weigh the potential self benefits and risks of participation must also be judged during data collection. The appointment of an independent relative or ombudsman must be considered if the client's ability to give informed consent is in question.

The need to obtain client consent to participate in followup research also presents a problem. Most frequently permission to recontact the client at some future followup point has not been solicited during the course of treatment. As such, recontacting must take place without consent in order to obtain consent for followup participation. A judgment about the extent to which this uninvited contact may unreasonably intrude into the client's life must be made. This issue must also be addressed when contacting other parties included in the research design, such as therapists or relatives of clients.

Finally, client ambivalence about participating in followup research is not uncommon, particularly when the research extends over a long period of time. Consent may be given at one point, for example,

and withdrawn at a later time. Multiple opportunities for cooperation or refusal must be incorporated in the followup data collection procedure. A thorough review of ethical issues in followup research has been presented by Showstack, Hargreaves, Glick, and O'Brien (1978).

Before closing this section, it should be noted that, in addition to its scientific purposes, the psychotherapy followup research design has the inherent potential to provide specific benefits to its participants. Former clients may, for example, positively experience the continued contact provided by followup because of its expression of interest in client well-being. It may also boost the morale of treatment staff because of its ongoing attention to their work. Furthermore, it can provide valuable feedback from clients and therapists to the treatment staff and administration on concerns they found to be relevant to continuation and improvement in the psychotherapy.

Summary

This review of the literature began by discussing the traditional short length of stay criterion used in clinical practice and research to classify clients as psychotherapy dropouts. Professional reliance upon a strictly temporal definition was understood within the context of professional beliefs about length of stay and improvement in therapy. Clients classified as dropouts have, by definition, had treatments of relatively short duration. By implication, these clients have had treatments of insufficient length, have rejected therapy as a means to solve their problems, and have not benefited from their brief treatment

contacts. In short, the label psychotherapy dropout goes beyond its temporal definition to imply treatment failure.

Whether or not dropouts are in fact the treatment failures that mental health professionals assume them to be was raised as a critical issue. Rhetorical arguments both in support of and against this assumption of failure were presented. The literature on outcome studies of dropouts, as well as research in the related field of spontaneous remission, was also reviewed. In contrast to traditional assumption, these studies suggest that at least some clients, traditionally classified as dropouts using the temporal criterion, clinically improve and experience a sense of well-being and satisfaction following their brief therapeutic encounters.

The failure of professionals to empirically validate their implicit assumption of treatment failure with short-term therapy clients was identified as a problem in the classification of dropouts. Empirical validation was considered critical in light of the fact that decisions, ranging in magnitude from individual clinical situations to federal policy and funding of mental health care services, are influenced by incidence of dropout given its implication of treatment failure. It was concluded that a revision in the short length of stay definition of dropout was needed in order to align what has traditionally been meant or implied by the term dropout with its operational definition. Toward this end, the criterion of lack of and/or negative therapeutic effect was recommended as a valuable addition to the short length of stay criterion for dropout classification.

Having established the need for empirical validation of treatment failure in the classification of dropouts, the critical issue of perspective in judgments of therapeutic outcome was introduced. Contemporary thinking in the field of psychotherapeutic outcome evaluation was reviewed and it was concluded that the view of the mental health professional and the client was necessary for a complete understanding of the impact of therapy in any given case.

To underscore the importance of evaluations of outcome from the point of view of clients in general, and psychotherapy dropouts in particular, several lines of argument were presented. Professional recognition of the client's view of outcome, as distinct from and validly equal to professional opinion, was established. The increasing demand of the consumer movement for client evaluations of outcome was discussed, and the clinical issues and empirical research related to evaluations of outcome by dropouts themselves were reviewed. Here it was suggested that professional classification of a client as a dropout may be more indicative of a disagreement between client and therapist about the goals to be achieved in treatment, than an accurate statement about whether or not any client change took place following the brief therapeutic contact. It was concluded that exclusive reliance upon professional standards and values as a basis for determining whether or not dropouts utilize treatment appropriately, effectively, and meaningfully was problematic. Detailed investigations of the self reported experience and outcome of dropouts have not been conducted however. It was

recommended, therefore, that research in the area of dropout self report be undertaken.

The philosophical and methodological issues attendant to self reports of treatment experience and outcome were reviewed next. The dilemma in human science research of needing to adhere to the principles of traditional scientific methodology while at the same time maintaining an appreciation for the individuality of experience was presented. The use of self report methodology, with its reliance and emphasis upon subjective knowledge, was valued as a means to balance the need for scientific observation and quantification with our fundamental personal realities. Acknowledgement of the self report method's limitations and its vulnerability to particular sources of bias was judged essential to its use. It was recommended that data be interpreted within the context of understanding the meaning and determinants of self report evaluations, with appropriate measures taken to reduce the likelihood of intrusion from bias.

A full investigation of the phenomena of dropping out of treatment was called for in the final section of this literature review. A longer term followup study was recommended as a means to gather information on the self reported therapeutic experience and outcome of dropouts, and on their self reported post-treatment functioning and clinical history. The philosophical, methodological, and ethical issues involved in psychotherapy followup studies were therefore reviewed.

The traditional model of psychotherapy outcome evaluation, which posits termination as the time to evaluate treatment effects and followup as the time to assess the stability of those effects, was critiqued. The timing of an outcome evaluation, whether it was during the process of therapy, at termination, or at some point following termination, was understood to differentially effect the nature of the evaluation data obtained. It was recommended that treatment evaluations, regardless of timing, be philosophically approached from a social systems perspective in which data are understood within the context of an appreciation for effect patterns and the ongoing nature of experience. This was contrasted with the traditional approach in which events are construed as fixed, isolated, and capable of determining the ultimate effectiveness, efficiency, and/or meaning of psychotherapy.

The overall lack of followup evaluations in the fields of both psychotherapy and behavior therapy was discussed. It was concluded that longer term followup research was needed given the relative absence of this type of research and the fact that followup assessments provide unique access to information necessary for an in depth investigation of dropping out of therapy and a thorough evaluation of treatment outcomes of dropouts.

The two major methodological approaches to followup research were reviewed, and sample representativeness, client attrition, and confounds from intercurrent events were identified as general design problems. The ethical concerns related to dealing with a clinical population and

the unique contact problems presented by a followup design were also discussed.

It was concluded that psychotherapy followup research, in addition to providing unique access to information that furthers scientific exploration of therapy, has the inherent potential to immediately benefit its participants by providing them with ongoing contact, interest, and feedback.

Purpose Of The Study

Statement Of The Problem

The term psychotherapy dropout is traditionally used to describe clients whose treatments have been abbreviated to the point that no benefit from contact is assumed likely. This assumption is based upon the professional belief that the longer clients remain in psychotherapy, the greater the likelihood of client gain from treatment.

There are three major problems with professional use of the term dropout, however. One has to do with the manner in which dropout has been operationalized in clinical practice and research. The second has to do with the term's deference to professional prerogative in judgments of psychotherapeutic effectiveness, efficiency, and meaning. The third has to do with the generally negative influence of dropout incidence statistics upon the continued support and practice of individual psychotherapy.

Problem 1. Concerning the definitional problem, professionals have tended to rely solely upon temporal criteria to operationally define psychotherapy dropout, in spite of the fact that the term connotes both abbreviated treatment and therapeutic failure. Recent research has indicated that many clients, classified as dropouts using the traditional short length of stay criteria, have clinically benefited from their brief therapeutic encounters. One problem, therefore, with the term dropout is the failure of professionals to explicitly validate their implicit assumptions of treatment failure with short-term therapy clients. As a result, incidence statistics on dropout have been spuriously inflated.

Problem 2. Concerning the problem of professional prerogative, the term dropout relies exclusively upon professional judgment of treatment failure with short-term therapy clients, by virtue of its definition, whether in the form of implicit assumption or explicit empirical validation. Contemporary thought in psychotherapy outcome research, however, considers evaluation from the perspectives of at least the mental health professional and the client necessary for a complete understanding of psychotherapeutic outcome in any given case. Furthermore, recent research has suggested that representation of both client and professional views of outcome is particularly critical in dropout classification given that there is a significant potential for discrepancy between client and therapist judgments of outcome. A second problem, therefore, with the term psychotherapy dropout is its lack of apprecia-

tion and representation of the dropout's view of outcome. The term's usefulness is thereby limited when it comes to providing comprehensive information on the effects of treatment.

Problem 3. Concerning the problem of negative influence, clinicians, mental health administrators, and politicians have interpreted incidence statistics on treatment dropout as grounds for questioning the ability of certain clients or types of clients to benefit from psychotherapy, the ability of certain therapists or types of therapists to adequately provide psychotherapeutic services, and the ability of individual psychotherapy itself to be an effective intervention modality for outpatient clinic populations. Yet there has been little empirical investigation of client reasons for dropping out treatment. Few studies have explored the psychological condition of dropouts at the time of termination, from either professional or client perspectives. Client opinions about what they did or did not get out of their brief treatment contacts have not been solicited, and few investigations into the post-treatment functioning and clinical history of dropouts have been conducted. A third problem, therefore, with the term psychotherapy dropout is its negative influence upon mental health service, policy, and funding in the absence of empirical evidence that warrants this type of negative reaction.

Statement Of The Purpose

The purpose of the present study is to address these problems associated with professional use of the term psychotherapy dropout.

In response to the first problem of definition, this study proposes to differentiate short-term therapy clients who have not improved from clients who have made clinical gains by professionally evaluating clinical outcome at termination.

In response to the second problem of professional prerogative in outcome evaluations, this study proposes to provide a more comprehensive picture of the effects of psychotherapy by soliciting the client's view of outcome as well as the professional's view.

In response to the third problem of lack of empirical data on dropouts, this study proposes to expand current knowledge about the phenomena of dropping out of treatment by exploring the therapeutic experience and outcome, post-treatment functioning, and clinical history of dropouts as reported by themselves.

Focal Points Of Inquiry

Clients who drop out of psychotherapy will be compared to other former psychotherapy clients to see whether or not dropouts are uniquely different from non-dropouts in terms of treatment failure.

Differences between dropouts and non-dropouts on client self reports of treatment experience and benefit, and post-treatment functioning and clinical history, will be further explored in terms of the differential and interactional effects of the variables of length of stay and clinical outcome.

Dropouts are defined as clients who have short lengths of stay in treatment and have not, in their therapists' opinions, clinically improved at point of termination.

The concept of treatment failure is based upon the three major assumptions of failure commonly associated with dropping out of treatment, as outlined by Baekeland and Lundwall (1975). These are: (1) Dropouts are lost to treatment forever; (2) Dropouts gain nothing from their brief treatment contacts; and (3) Dropouts remain clinically unchanged and in psychological need following termination from treatment. Items from a client self report followup questionnaire serve as the dependent measure and are arranged in accord with each of these assumptions.

CHAPTER III

METHOD

All data used in the present study are from the data base of the Psychotherapy Followup Project of the Katharine Wright Clinic of Illinois Masonic Hospital, Chicago, Illinois. The project, designed to investigate the long term effects of individual psychotherapy, utilized mail questionnaires and clinic records as a means to gather information. The sample, instruments, and data collection procedures of the project are detailed below. Procedures for preparing the raw data for statistical analysis are also described in this chapter.

The Sample

Client Followup Sample

The client followup sample consisted of 64 former clients who had been in individual outpatient psychotherapy at the Katharine Wright Clinic of Illinois Masonic Hospital. Treatment lengths ranged from 1 to 113 sessions, with a median length of 18, and treatments were generally held on a once weekly basis. Eighty percent of the sample had closing diagnoses of depressive neurosis, and on the average were rated at termination as having experienced slight to moderate improvement. All clients had treatment termination dates between January 1972 and June 1976, and the average amount of time between termination and followup was 5 years.

The sample was 77% female and 23% male. Approximately two-thirds was single, and the median age was 28 years. Almost all had at least a high school education, and 81% were gainfully employed. A little less than half had had previous outpatient psychotherapy and only 9% had an inpatient treatment history. This sample was fairly representative of an urban outpatient population (Ryan, 1969). Characteristics of the client followup sample are summarized in Table 1.

Therapist Followup Sample

The clients were in treatment with 26 therapists (17 males, 9 females). Each therapist saw anywhere from 1 to 10 clients, with a median of 2 clients per therapist. The therapists' median age was 43 years, and 39% were currently married. They had been trained in psychiatry, clinical psychology, and psychiatric social work, and had a median of 15 years of experience. Their theoretical orientation was predominantly dynamic-eclectic, and 87% had undergone personal therapy. The therapist followup sample was fairly representative of the national urban sample of psychotherapists studied by Henry (1977). Characteristics of the therapist followup sample are summarized in Table 1.

Instruments

The following instruments were developed or selected for use in the project: (1) Psychotherapy Followup Questionnaire; (2) Outcome Ratings of Therapist Closing Notes (Tovian, 1977); (3) Evaluation of Symptom Change from Treatment Summaries (Tovian, 1977); and (4) Brief Symp-

TABLE 1

Summary Of Followup Sample Characteristics

Characteristic	Client Sample (N = 64)	Therapist Sample (N = 26)
	CURRENT LIFE STATUS	
Sex		
male	23%	65%
female	77%	35%
Age		
range	18-65 years	27-83 years
median	28	43
Marital Status		
single	59%	46%
married	14%	39%
separated/divorced/widowed	27%	15%
Parental Status		
no children	72%	73%
parents	28%	27%
Employment Status		
currently employed	80%	100%
currently unemployed	19%	-
number of missing cases	(1)	
Social Class[a]		
upper and upper middle	19%	100%
middle	49%	-
lower middle	26%	-
upper lower	-	-
lower and lower lower	6%	-
number of missing cases	(1)	
Education		
graduate school	11%	100%
completed college	22%	-
some college	40%	-
completed high school	22%	-
some high school or less	5%	-

Table 1 -- Continued

Characteristic	Client Sample (N = 64)	Therapist Sample (N = 26)
CURRENT LIFE STATUS (continued)		
Race		
Black	3%	4%
White	94%	92%
Latin	2%	-
Oriental	1%	-
Other	-	4%
PERSONAL AND FAMILY BACKGROUND		
Religious Background		
Protestant	35%	20%
Catholic	38%	20%
Jewish	18%	48%
Other/None	9%	12%
number of missing cases	(9)	(1)
Social Class of Origin[b]		
upper and upper middle	33%	35%
middle	17%	17%
lower middle	17%	48%
upper lower	15%	-
lower and lower lower	18%	-
number of missing cases	(4)	(3)
Family Size		
only child	6%	26%
1 sib	25%	26%
2 sibs	22%	31%
3 sibs	24%	4%
4-5 sibs	14%	13%
6-9 sibs	9%	-
number of missing cases		(3)
Birth Order		
only	6%	26%
oldest	42%	13%
middle	34%	31%
youngest	17%	30%
number of missing cases		(3)

Table 1 -- Continued

Characteristic	Client Sample (N = 64)	Therapist Sample (N = 26)
PERSONAL AND FAMILY BACKGROUND (continued)		
Age at Family Disruption		
under 5 years	12%	
6-10 years	10%	
11-15 years	10%	
16+ years	24%	
never	43%	
number of missing cases	(6)	
CLIENT THERAPEUTIC STATUS AND CURRENT TREATMENT INFORMATION		
Previous Outpatient Psychotherapy		
yes	41%	
no	59%	
number of missing cases	(1)	
Previous Inpatient Psychotherapy		
yes	9%	
no	91%	
Source of Referral to KWC		
self	5%	
family member	9%	
friend	27%	
physician	3%	
private therapist	5%	
institutional support system	51%	
Number of Wait List Days (Between Intake And 1st Session)		
range	6-99+ days	
median	36	
Treatment Recommendation After Intake		
insight-oriented therapy	59%	
supportive therapy	30%	
supportive+medication therapy	11%	

Table 1 -- Continued

Characteristic	Client Sample (N = 64)	Therapist Sample (N = 26)
CLIENT THERAPEUTIC STATUS AND CURRENT TREATMENT INFORMATION (continued)		
Medication During Treatment		
antidepressant	9%	
tranquilizer	13%	
none	78%	
number of missing cases	(1)	
Closing Diagnosis		
depressive neurosis	80%	
anxiety neurosis	11%	
hysterical neurosis	1%	
obsessive compulsive neurosis	3%	
other	5%	
Length of Stay (number of sessions)		
range	1-113	
median	18	
mean	27	
S.D.	27	
Clinical Outcome At Termination		
range	8.0-14.0	
median	11.3	
mean	11.2	
S.D.	2.1	
Number Of Years Between Termination And Followup		
3-4 years	30%	
5 years	26%	
6+ years	44%	

Table 1 -- Continued

Characteristic	Client Sample (N = 64)	Therapist Sample (N = 26)
THERAPIST PROFESSIONAL STATUS		
Profession		
psychiatrist		62%
clinical psychologist		19%
psychiatric social worker		19%
Years of experience		
range		<1-33 years
median		15
Personal psychotherapy		
yes		87%
no		13%
number of missing cases		(3)

Note. Information on each demographic variable for every client and therapist in the followup sample was not available. The percentages presented in this table have been adjusted to the number of cases available per variable. Where applicable, the number of missing cases has been specified.

[a]Social class standing was calculated using the Hollingshead-Redlich (1958) two-factor index of social position.

[b]Social class of origin was based on father's occupation.

tom Inventory (Derogatis, 1978). All of these instruments, except the Brief Symptom Inventory, were selected for use in the present study and will be described in detail below. The Psychotherapy Followup Questionnaire is reproduced in Appendix A. The Outcome Ratings of Therapist Closing Notes Form and the Evaluation of Symptom Change from Treatment Summaries Form are reproduced in Appendix B.

Followup Measure

The Psychotherapy Followup Questionnaire is a 56-item questionnaire specifically developed for use in the Psychotherapy Followup Project. It has both open-ended and structured response questions and is designed to be self-administered. The questionnaire focuses upon three major areas of client experience: (1) characteristics of treatment experience; (2) the impact of treatment; and (3) the client's post-treatment history.

With regard to characteristics of treatment experience, clients are asked to report on who initiated termination from treatment, and to describe their reasons for termination. Clients are also asked about their global satisfaction with therapy, specific benefits they may or may not have received from therapy, their liking of the therapist, and their perceptions of the therapist's liking of them.

Regarding treatment impact, clients are asked to make judgments about the positive and/or negative influence of treatment, since termination, in the following areas: in general, in their relationships overall, in their overall ability to deal with new problems or symptoms,

and in their ability to deal with their specific presenting symptoms, specific relationships and role performances, and in their management of personal life stresses.

With regard to post-treatment history, clients are asked to make judgments about their current level of functioning, both in general and with specific regard to the symptoms and problems they originally entered treatment for. Inquiry is also made into client self-satisfaction with current specific relationships and performance in various roles, and their felt need for further treatment. Whether or not clients reentered treatment at some point following termination from their therapy at the clinic is also asked about.

At the close of the questionnaire, clients are asked to rate their confidence in the accuracy of their responses. Of the 64 clients who participated in the followup project, 94% felt fairly confident, 3% did not feel confident about many of their responses, and 3% did not answer the question. These findings suggest that client responses to the questions are reliable to the extent that confidence in accuracy reflects reliability.

Outcome Measures

Two measures, developed in previous research at the Katharine Wright Clinic (Tovian, 1977) were used to evaluate therapeutic outcome at termination: (1) an Evaluation of Symptom Change from Treatment Summaries Form; and (2) an Outcome Ratings of Therapist Closing Notes Form.

The development of these measures had been tailored to the specific policy of recordkeeping at the clinic. Specifically, clinic policy required each therapist to write a treatment summary on each of her or his clients every month. The therapist was further required to write a closing note at termination of the psychotherapy which summarized the course of treatment and assessed the progress made.

The Outcome Ratings of Therapist Closing Notes Form delineated nine scales focusing on therapist identification of client-relevant parameters of therapy outcome. Two judges independently rated these scales, based upon therapist closing notes.

The Evaluation of Symptom Change from Treatment Summaries Form required judges to independently identify specific problems to be changed in the course of treatment. This information was taken from the therapist's initial treatment summary and allowed for the identification of a maximum of five problems. An independent rating of the amount of change effected for each problem over the course of treatment was then made by the judges based solely upon the therapist closing note.

Only 6 of the 14 scales from these two outcome measures allowed for both positive and negative change to be rated: Scale 1 (Patient's Condition at Closing) from the Outcome Ratings of Therapist Closing Notes Form and Scales A, B, C, D, and E (Rating of Problem Change at Closing) from the Evaluation of Symptom Change from Treatment Summaries Form. Ratings for each scale ranged from a score of 1 (considerably worse) to a score of 7 (considerably improved). A middle score of 4 indicated no change. These scales can be seen in Appendix B.

As direction and degree of global and symptomatic change were of focal interest in the present study, these six scales were selected for use in calculating a clinical outcome at termination score for each case in the project. The number of scales used for any one case varied depending upon the number of target problems identified by the raters.

To determine the strength of this clinical outcome measure, the inter-rater reliabilities of the six clinical scales were analyzed using Pearson correlations. Inter-rater correlations for the scales ranged from .71 to .88, as can be seen in Table 2, indicating that substantial inter-rater agreement was obtained on all of the scales used to calculate the outcome at termination score. The inter-rater reliabilities of these six scales, using different raters, was also analyzed in a previous study by Tovian (1977). Tovian reported substantial inter-rater agreement on the six scales, with correlations ranging from .74 to .96.

To examine the relationships between these six scales, inter-item correlations were calculated using a Pearson r. Table 3 presents the inter-item correlation matrix of the raters' scores for each of the six scales. It shows that the inter-item correlations among the variables were relatively high, with correlations ranging from .34 to .96, and thus little was differentiated among them. These six variables may therefore be conceptualized as measuring a unitary outcome variable and as such be combined to form a single clinical outcome at termination assessment.

TABLE 2

INTER-RATER CORRELATIONS OF CLINICAL OUTCOME SCALES

Outcome Variable	Pearson *r*
(1) Patient's Condition at Closing	.88**
(2) Change in Problem A	.74**
(3) Change in Problem B	.73**
(4) Change in Problem C	.75**
(5) Change in Problem D	.71**
(6) Change in Problem E	.83*

*$p < .05$.
**$p < .001$.

TABLE 3

INTER-ITEM CORRELATION MATRIX OF CLINICAL OUTCOME SCALES FOR RATERS I AND II

Outcome Variables	Rater I						Rater II					
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Rater I												
(1) Condition At Closing	--	.83	.77	.78	.73	.62	.88	.72	.79	.72	.68	.87
(2) Change In Symptom A		--	.83	.81	.79	.56**	.83	.74	.74	.62	.62	.93
(3) Change In Symptom B			--	.74	.81	.53**	.79	.69	.73	.62	.64	.77**
(4) Change In Symptom C				--	.72	.34[a]	.79	.68	.69	.75	.63	.82*
(5) Change In Symptom D					__	.69	.73	.64	.74	.68	.71	.76**
(6) Change In Symptom E						__	.59	.43*	.43*	.63	.56**	.83*
Rater II												
(7) Condition At Closing							--	.74	.78	.77	.66	.85
(8) Change In Symptom A								--	.78	.67	.80	.93
(9) Change In Symptom B									--	.74	.82	.96
(10) Change In Symptom C										--	.72	.93
(11) Change In Symptom D											--	.93
(12) Change In Symptom E												--

Note. Unless otherwise indicated, all probability values are less than .001.

*$p < .05$.

**$p < .01$.

[a] non-significant.

To obtain a numerical score of outcome for a given case, the following calculation was performed: (Rater 1's Condition at Closing Score) plus (the mean of Rater 1's Problem Change Scores) plus (Rater 2's Condition at Closing Score) plus (the mean of Rater 2's Problem Change Scores) divided by 2. The possible score for any given client ranged from 2 to 14, with a score of 2 indicating the greatest amount of negative change and a score of 14 indicating the greatest amount of positive change.

Procedure

At the beginning of the project, code numbers were assigned to all clients and therapists and were used throughout data collection and analysis.

The Clinic Setting

The Katharine Wright Clinic is an outpatient mental health facility serving a low to moderate income urban population. The clinic's theoretical approach to treatment is dynamic-eclectic and treatment tends toward a traditional longer term model. All clients in the project were in individual psychotherapy, mostly on a once-weekly basis, and therapy sessions were normally of 45-minute duration.

Selection Of The Client Sample

The initial selection of clients for the Psychotherapy Followup Project was made on the basis of termination date. All clients in therapy at Katharine Wright Clinic in the Department of Mental Health's high

risk program who terminated between January, 1972 and June, 1976 were included. To this initial sample of psychotherapy cases (N = 500), the following selection criteria were applied: (1) individual psychotherapy; (2) 18 years of age or older at intake; (3) no organic or other physical complication; and (4) a primary closing diagnosis within the DSM-II neurotic or adjustment reaction range. A total of 194 cases qualified for inclusion in the client sample.

An attempt was made to contact each of these 194 cases, either by telephone or by mail, to request their participation in the followup project. Followup contact was achieved with 92 former clients. Of these, 64 agreed to participate in the study and actually did so by filling out and returning the research forms sent to them. The remaining 28 former clients refused participation either directly during telephone contact (n = 12) or indirectly by agreeing to participate in the project but not returning the research forms (n = 16).

Followup Contact Policies And Procedures

A number of precautions were taken and incorporated into the followup data collection procedures in order to protect client confidentiality and right of refusal. A private phone line was installed to ensure that the number used during followup data collection was not traceable to a mental health clinic. All envelopes used to mail materials had return addresses that did not identify the clinic by name. If someone other than the former client was contacted by telephone, no reference to the clinic was made although a request for the former client

to return the call was permitted. When contact with the former client was achieved, careful attention was paid to inform him or her of the right to refuse participation as well as to the need for reassurance that participation or refusal was confidential, would not become part of clinic records, and would not have a bearing upon future access to service at the clinic. Emphasis upon the anonymity of participation was also made in the hopes of encouraging former clients to respond more in accord with their consciences and less in accord with demand characteristics and/or evaluation apprehensions.

Method of contact involved several steps, depending upon whether or not contact with the former client was achieved. Telephone contact was attempted first, using the home phone number listed in the chart. If this phone number was invalid, the latest Chicago phone book was referenced to update chart information, if possible. If no contact was achieved through this means, the work number listed in the chart was used. If this was not successful, the emergency contact phone number from the chart was utilized, provided permission to contact was explicitly noted in the chart. At no time during telephone contact attempts was information regarding the source or purpose of the call revealed unless the former client was personally reached.

Attempt to contact by telephone was made three times after which, if no refusal or contact was achieved, a mail request was made. This final attempt at contact was made by mailing a letter to the last known address listed in the chart. A self-addressed stamped envelope on which

to return a card indicating acceptance or refusal to participate was mailed along with a letter requesting participation. These materials are reproduced in Appendix C.

If consent to participate was obtained, either via telephone or mail, the followup research forms were mailed along with a cover letter reiterating the purpose of the research and the confidentiality and anonymity of response, as well as a self-addressed, stamped envelope in which to return the materials. This letter is reproduced in Appendix C. If consent was obtained, but the research materials were not returned, the former client was recontacted once to inquire about intent to participate. If following this contact the materials were not returned, the case was considered a refusal.

The followup data collection phase of the project ran from February 15, 1979 to June 15, 1979.

Demographic Data Collection Procedures

Client demographics and treatment variables, such as use of medication during treatment, closing diagnosis, and number of sessions attended, were obtained directly from the client's chart and collected on the 64 cases in the followup sample. For purposes of establishing representation and bias of the followup sample, demographic and treatment data was also collected on the remaining 130 cases that qualified for inclusion in the followup sample but were either not located or were located but declined participation in the research.

For therapist demographics, each therapist was either hand- or mail-delivered a demographic data form with an accompanying cover letter requesting participation in the project. A self-addressed, stamped envelope was enclosed for return of the research form. For therapists who could not be located, limited demographics were obtained through the clinic administration.

The materials for client and therapist demographic data collection are reproduced in Appendix D.

Clinical Outcome Evaluation Procedures

Clinical outcome at termination was rated for the 64 cases that filled out and returned the followup questionnaire, for the 28 cases that declined to participate in the followup phase of the project, and for a sample of 20 cases that was randomly selected from the 102 cases with whom followup contact was not achieved. These samples will hereafter be referred to, respectively, as the followup sample (n = 64), the refusal sample (n = 28), the no-contact subsample (n = 20), and the general no-contact sample (n = 102). In all, clinical outcome at termination was rated for 112 of the 194 cases that met the selection criteria for inclusion in the followup sample.

Evaluations of clinical outcome at termination were made, independently, by two advanced graduate students in clinical psychology using the previously described outcome evaluation forms. The Outcome Ratings of Therapist Closing Notes Form was rated first for all cases, and the Evaluation of Symptom Change Form was rated last.

For the Evaluation of Symptom Change Form, each rater could specify between one and five symptom change areas for each case. In order to calculate the clinical outcome at termination score for each case, and determine the inter-rater reliability of the outcome measures as used in the present study, the symptom change areas specified by the two raters were matched. A clinical psychologist independently aligned these content areas. In over 75% of the cases, the only difference between the raters was the order in which they listed the symptom change areas. In about 25% of the cases, the differences were primarily those of one rater broadly defining a symptom change area and thereby incorporating two or more of the other rater's narrowly defined areas. In cases such as these, if the same change scores were assigned to a rater's narrowly defined symptom change areas, these areas were collapsed to form one symptom change area and paired with the broadly defined symptom change area of the other rater. If, however, the rater assigned different change scores to the narrowly described symptom change areas, then these symptom change areas were retained and the other rater's broadly described symptom change area was expanded to match the number of symptom change areas of the other rater.

There were only two instances (about 2% of the sample) where the nature of the symptom change areas specified by each rater was difficult to match without using some form of interpretation. In these instances, the difficulty was resolved by conferring with raters about their judgments to determine whether or not their respective symptom change areas should be paired or left separate.

The number of scales used for any one case varied depending upon the number of symptom change areas identified by the raters. Also, only those problems agreed upon by both raters were included.

Determination Of Cutoff Points For Dropout Criteria

The variables of length of stay and clinical outcome at termination were used to define the term psychotherapy dropout and were studied as independent variables in the analysis of variance section of the present work. The rationale for determining cutoff points for these two variables, given their continuous nature, is described below.

Given the argument that professional use of the term dropout has generally implied no benefit from treatment, a cutoff point for clinical outcome at termination was selected so that clients who benefited from treatment could be differentiated from clients who received no benefit.

In the followup sample, the variable of clinical outcome ranged from a score of 8 to 14, with a median of 11 (M = 11.2; SD = 2.1), and a score of 9.9 was selected as the cutoff point. This cutoff point ensured that no case could be classified as a psychotherapy dropout if both raters agreed, on the average, that at least slight improvement had occurred.

Given the argument that professional use of the term dropout has generally implied treatments of relatively short duration, a length of stay cutoff point was selected so that clients who were in treatments for at most a 3-month period could be differentiated from clients in lengthier treatments.

In the followup sample, the variable of length of stay ranged from 1 to 113 sessions, with a median of 18 sessions (M = 26.6; SD = 26.9), and a treatment of 14 sessions was selected as the cutoff. This cutoff point seemed reasonable given that the model of treatment practiced at the clinic at the time was a traditional longer term model and therapies terminated within a 3-month period were generally considered short. In addition, because many clients participated in relatively lengthier treatments at the clinic, a 14-session cutoff was also selected to ensure that a sufficient number of subjects could be assigned to the short-term group to allow for statistical comparison.

Clients who had clinical outcomes of 9.9 or less and lengths of stay of 14 sessions or less were considered psychotherapy dropouts.

Categorization And Arrangement Of Dependent Variables

Items taken directly or created from the Psychotherapy Followup Questionnaire were the dependent variables in the present study. For purposes of statistical analysis, questionnaire items, if not originally formatted as interval data, were recategorized, via research team consensus, to allow for treatment as interval data. Qualitative data from the open-ended questions of the questionnaire were also assigned to ordered categories, via research team consensus, for purposes of data analysis.

Each questionnaire item was assigned to one of three groups, depending upon the professional assumption of treatment failure it related to. The three assumptions of failure, outlined by Baekeland and

Lundwall (1975), are: (1) Dropouts are lost to treatment forever; (2) Dropouts gain nothing from their brief treatment contacts; and (3) Dropouts remain clinically unchanged and in psychological need following termination. A group comprised of items related to characteristics of treatment was also formed. Group assignment of questionnaire items can be seen in Appendix E.

Summary

There were 194 cases that qualified for inclusion in the Psychotherapy Followup Project. They were classified in one of four groups: (1) the followup sample (n = 64); (2) the refusal sample (n = 28); (3) the general no-contact sample (n = 102); and (4) the no-contact subsample (n = 20). The general no-contact sample was comprised of all uncontacted cases. The no-contact subsample was a randomly selected subsample of the general no-contact sample.

Client demographic, therapist demographic, and treatment variable data were collected on the cases in all 194 cases. Clinical outcome ratings at termination were made on cases in the followup sample, the refusal sample, and the no-contact subsample. Data from the Psychotherapy Followup Questionnaire was obtained only on cases in the followup sample.

CHAPTER IV

RESULTS

Analyses to establish the representativeness of the followup sample are presented first, and a description of the statistics used to analyze the followup questionnaire data is presented next. The results of these statistical analyses are presented last and organized under the following categories: (1) Characteristics Of Treatment; (2) the assumption that Dropouts Are Lost To Treatment Forever; (3) the assumption that Dropouts Gain Nothing From Their Brief Treatment Contacts; and (4) the assumption that Dropouts Remain Clinically Unchanged And In Psychological Need Following Termination.

Representativeness Of The Followup Sample

In order to establish the extent to which the followup sample represented the general clinic outpatient population, comparisons were made between the followup sample and the refusal sample, and the followup sample and the no-contact samples on client demographics, client therapeutic status and treatment information, therapist demographics, and clinical outcome at termination.

Client demographics included current life status variables (age, race, sex, marital status, parental status, employment status, education, and social class status), and personal and family background vari-

ables (birth order, family size, age at family disruption, religious background, and social class background).

Client therapeutic status and treatment information included the variables of previous inpatient treatment, previous outpatient treatment, referral source, number of days on the waiting list, type of treatment recommended, medication taken during treatment, length of treatment, final diagnosis, and number of months between termination and followup contact.

Therapist demographics included current life status variables (age, race, sex, marital status, and parental status), personal and family background variables (birth order, family size, religious background, and social class background), and professional status variables (profession, personal therapy, and years of experience).

Clinical outcome at termination included the clinical outcome at termination score and the scales used to compute that score.

Variables with categorical data were analyzed using a Chi-square statistic, and variables with interval data were analyzed with the *t*-test. All analyses of therapist variables were based upon client-therapist pairs and, as such, some therapists were included more than once. In addition, given the large number of comparisons made on this group of data, probability values of .05 were interpreted as indicating trends, and probability values of .01 or less were interpreted as indicating real differences.

Comparisons Between The Followup And Refusal Samples

Analyses comparing the followup sample to the refusal sample gave the following results:

Client demographics. There were no significant differences or trends between the samples, except on the variable client employment status. A Chi-square analysis of this variable indicated a trend in which there were more full-time workers and fewer part-time workers in the followup sample than in the refusal sample (73% versus 50% full-time, respectively, and 8% versus 29% part-time, respectively; $X^2(2) = 7.39$, $p < .03$). There were no differences between the samples on level of unemployment, however.

Client therapeutic status and treatment variables. There were no significant differences or trends between the samples on variables in this category.

Therapist demographics. For therapist demographics, there were no significant differences or trends between the samples, except on the variable years of experience. The t-test analysis of this variable indicated a trend in which followup sample therapists were slightly less experienced than refusal sample therapists (Ms = 15 years and 18.5 years, respectively; $t(90) = 2.04$, $p < .02$).

Clinical outcome at termination. The results of the analyses comparing the followup sample to the refusal sample on clinical outcome at

termination are presented in Table 4. There were no significant differences or trends between the samples, except on the scale Change in Problem C. The t-test analysis of this variable indicated that the followup sample had slightly greater improvement on this problem than the refusal sample (Ms = 5.78 and 4.79, respectively; $t(54) = 3.45$, $p < .002$).

Comparisons Between The Followup And No-Contact Samples

Analyses comparing the followup sample to the no-contact samples gave the following results:

Client demographics. There were no significant differences between the followup sample and the general no-contact sample on variables in this category, but there were several trends. There was a trend indicating that clients in the followup sample were slightly older than clients in the general no-contact sample (Ms = 30 years and 27 years, respectively; $t(164) = -2.17$, $p < .05$). There was a trend indicating that the followup sample had more full-time workers and less unemployed people than the general no-contact sample (73% versus 51% full-time, respectively, and 19% versus 39% unemployed, respectively; $X^2(2) = 8.45$, $p < .05$. There were also trends indicating that the followup sample had fewer youngest-born clients than the general no-contact sample (17% and 37%, respectively; $X^2(2) = 8.15$, $p < .05$), and had clients who came from slightly larger families than the general no-contact sample (Ms = 2.8 sibs and 2.0 sibs, respectively; $t(140) = -2.36$, $p < .05$).

TABLE 4

THE *t*-TESTS COMPARING THE FOLLOWUP AND REFUSAL SAMPLES ON CLINICAL OUTCOME AT TERMINATION

Outcome Scale	Means		t	df	p
	Followup	Refusal			
Condition At Closing[a]	5.61	5.27	1.33	90	.186
Change in Problem A[a]	5.69	5.27	1.47	76	.146
Change in Problem B[a]	5.65	5.47	.64	69	.525
Change in Problem C[a]	5.78	4.79	3.45	54	.001
Change in Problem D[a]	5.67	5.55	.30	32	.767
Change in Problem E[a]	5.33	7.00	-1.39	2	.300
Clinical Outcome At Termination Score[b]	11.22	10.54	1.44	90	.154

[a]Scores range from 1 to 7 with a score of 5 or greater indicating at least slight improvement.

[b]Scores range from 2 to 14 with a score of 10 or greater indicatin at least slight improvement.

Client therapeutic status and treatment variables. There were no significant differences between the two samples on these variables, but there were two trends. There was a trend indicating that the followup sample had more clients with no previous history of outpatient treatment than the general no-contact sample (59% and 42%, respectively; $X^2(2) = 4.57$, $p < .05$). There was also a trend indicating that the followup sample had proportionately more clients in the 3- to 4-year post-treatment range than the general no-contact sample (30% and 14%, respectively; $X^2(2) = 6.97$, $p < .03$).

Therapist demographics. There were no trends or significant differences between the followup and general no-contact samples on these variables.

Clinical outcome at termination. The results of the analyses comparing the followup sample to the no-contact subsample on clinical outcome at termination are presented in Table 5. No significant differences were found between the two samples except on the Change in Problem C scale. Clients in the followup sample had greater improvement on this problem than clients in the no-contact subsample (Ms = 5.78 and 4.88, respectively; $t(47) = 2.79$, $p < .01$). In addition, two trends were found on the Change in Problem B scale and the Clinical Outcome At Termination Score that indicated the followup sample had greater improvement on Problem B than the no-contact subsample (Ms = 5.65 and 4.97, respectively; $t(67) = 2.34$, $p < .03$), and had greater improvement

on the overall outcome score than the no-contact subsample (Ms = 11.22 and 9.97, respectively; $t(82) = 2.45$, $p < .02$).

Summary

Overall, the followup sample was not essentially different from the refusal sample in terms of client demographics, client therapeutic status and treatment information, therapist demographics, and clinical outcome at termination.

There were also no essential differences between the followup and general no-contact samples in terms of client demographics, client therapeutic status and treatment information, and therapist demographics. For clinical outcome at termination, however, results indicated that the followup sample was significantly different from the no-contact subsample on one clinical outcome scale and there were two trends in the same direction on one other clinical outcome scale and the clinical outcome at termination score. For these variables, the followup sample was rated as having improved slightly to moderately, on the average, whereas the no-contact subsample was rated as having not improved to having slightly improved, on the average.

Statistical Approaches To The Data

To determine the uniqueness of psychotherapy dropouts in terms of treatment failure and certain characteristics of treatment, three different statistics were applied to the followup questionnaire data: (1) t-tests comparing dropouts to all other former psychotherapy clients;

TABLE 5

THE t-TESTS COMPARING THE FOLLOWUP SAMPLE AND THE NO-CONTACT SUBSAMPLE ON CLINICAL OUTCOME AT TERMINATION

Outcome Scale	Means		t	df	p
	Followup	No-Contact			
Condition At Closing[a]	5.61	4.98	2.28	82	.025
Change in Problem A[a]	5.69	5.28	1.34	70	.184
Change in Problem B[a]	5.65	4.97	2.34	67	.022
Change in Problem C[a]	5.78	4.88	2.79	47	.008
Change in Problem D[a]	5.67	5.25	1.09	30	.285
Change in Problem E[a]	5.33	5.75	-.34	3	.754
Clinical Outcome At Termination Score[b]	11.22	9.97	2.45	82	.016

[a]Scores range from 1 to 7 with a score of 5 or greater indicating at least slight improvement.

[b]Scores range from 2 to 14 with a score of 10 or greater indicating at least slight improvement.

(2) one-way ANOVAs comparing the four length of stay/outcome groups; and (3) two-way ANOVAs of the variables of length of stay and clinical outcome on specific followup questionnaire variables. The purpose of each statistical approach is detailed below, along with the summary statistics for that approach.

The t-Test Comparisons

Dropouts (clients who had short lengths of stay and were professionally judged unimproved at termination: short-term/unimproved) were compared, by means of a t-test, to a non-dropout group comprised of all other former psychotherapy clients (long-term/unimproved, short-term/improved, and long-term/improved) to determine the uniqueness of dropouts in terms of certain characteristics of treatment and the three assumptions of treatment failure commonly associated with dropping out of treatment.

Summary statistics for the two comparison groups were as follows: The dropout group had an n of 14 clients, length of stay ranged from 1 to 9 sessions, with a median of 3 sessions and a mean of 4 sessions, and the clinical outcome at termination score ranged from 8.0 to 9.8, with a median of 8.0 and a mean of 8.8. The non-dropout group had an n of 50 clients, length of stay ranged from 3 to 113 sessions, with a median of 25 sessions and a mean of 33 sessions, and the clinical outcome at termination score ranged from 8.0 to 14.0, with a median of 12.3 and a mean of 11.6.

Given the large number of comparisons made on these data, probability values of .05 were interpreted as indicating trends, and probability values of .01 or less were interpreted as indicating real differences.

One-Way Analyses Of Variance

The four length of stay/outcome groups (short-term/unimproved, long-term unimproved, short-term/improved, and long-term/improved) were compared, by means of a one-way analysis of variance, to determine the frequency with which the groups differed from each other. Analyses significant at the .05 level or less were probed using the Duncan's procedure.

Summary statistics for these four comparison groups were as follows: (1) the short-term/unimproved (dropout) group had an n of 14 clients, length of stay ranged from 1 to 9 sessions with a median of 3 sessions and a mean of 4 sessions, and the clinical outcome at termination score ranged from 8.0 to 9.8 with a median of 8.0 and a mean of 8.8; (2) the long-term/unimproved group had an n of 5 clients, length of stay ranged from 16 to 59 sessions with a median of 36 sessions and a mean of 31 sessions, and the clinical outcome at termination score ranged from 8.0 to 9.9 with a median of 9.7 and a mean of 9.4; (3) the short-term/improved group had an n of 14 clients, length of stay ranged from 3 to 14 sessions with a median of 8 sessions and a mean of 7 sessions, and the clinical outcome at termination score ranged from 10.3 to 13.8 with a median of 11.0 and a mean of 11.7; and (4) the long-term/im-

proved group had an n of 31 clients, length of stay ranged from 15 to 113 sessions with a median of 34 sessions and a mean of 44 sessions, and the clinical outcome at termination score ranged from 10.0 to 14.0 with a median of 12.7 and a mean of 12.6.

Two-Way Analyses Of Variance

The followup questionnaire data was also analyzed in the context of a factorial design with length of stay as Variable LOS and clinical outcome at termination as Variable OUT. There were two levels of each variable: short (1-14 sessions) and long (15+ sessions) for length of stay; and unimproved (8.0-9.9) and improved (10.0-14.0) for clinical outcome at termination.

For purposes of this study, a followup questionnaire variable was explored for differential and interactional effects of length of stay and outcome, by means of a two-way analysis of variance, only when t-test analysis of the variable indicated significant differences between the dropout and non-dropout groups at the .05 level or less. Since data examined by these 2 by 2 ANOVAs have already been found to significant at the .05 level or less, a significance level of .10 or less was interpreted as indicating real differences. Significant interactional effects were probed using the Duncan's procedure at the .05 level.

The distribution of clients among the levels of the independent variables was as follows: (1) 44% of the sample (n = 28) had therapies of 14 sessions or less, (2) 30% of the sample (n = 19) had therapies

rated as unimproved at termination, (3) of the short-term group, 50% were unimproved (n = 14), and (4) of the long-term group, 14% were unimproved (n = 5). A Chi-square comparing length of stay to clinical outcome indicated a significant relationship between these two variables with unimproved clients being overly represented in the short-term group and improved clients being overly represented in the long-term group, $X^2(1) = 8.19$, $p = .004$. Despite this strong positive relationship between length of stay and outcome, however, 50% of the cases that would have traditionally been classified as psychotherapy dropouts, using a short length of stay criterion alone, were professionally judged improved at termination.

Characteristics Of Treatment

The t-Test Comparisons Between Dropouts And All Other Former Clients

Table 6 presents the results of t-test comparisons between dropouts and non-dropouts on the 11 variables categorized under Characteristics Of Treatment. There were no significant differences between the groups on these variables. On the average, both groups reported being moderately to greatly troubled by their problems or symptoms at the beginning of therapy (group Ms ranged from 3.65 to 3.96), experienced moderate to great difficulty in dealing with specific problem areas in their lives at the beginning of therapy (group Ms ranged from 3.33 to 3.60), and were mixed in terms of whether they felt comfortable or uncomfortable with other people prior to treatment.

TABLE 6

THE t-TESTS COMPARING DROPOUTS TO NON-DROPOUTS ON CHARACTERISTICS OF TREATMENT

Followup Question	Means[a] Dropouts	Non-Dropouts	t	df	p
How much were each of the problems or symptoms you listed above troubling to you at the time you began therapy at KWC?					
Symptom/Problem A	3.93	3.84	.86	61	.395
Symptom/Problem B	3.83	3.96	.80	49	.428
Symptom/Problem C	3.75	3.65	.45	37	.653
Symptom/Problem D	3.75	3.65	.32	22	.754
How would you rate your ability to deal with these problem areas when you began therapy at KWC?					
Problem Area A	3.50	3.60	-.45	55	.655
Problem Area B	3.33	3.52	-.81	40	.423
Problem Area C	3.60	3.52	.24	28	.815
Problem Area D	3.75	3.47	.82	17	.426
Prior to treatment, did you or did you not feel uncomfortable or ill at ease with other people?	1.53	1.68	-.95	61	.348
How did you feel about your therapist as a person?	2.35	1.78	1.88	61	.065
How did your therapist feel about you as a person?	2.00	1.51	2.01	46	.050

[a]The higher the mean score, the greater the degree of discomfort, difficulty, or disliking. For ranges and values of specific questions, see Appendix E.

There was a trend indicating that dropouts felt less liked by their therapists than non-dropouts (M = 2.00 and M = 1.51, respectively; $t(46) = 2.01$, $p = .054$), although both groups on the average felt at least some liking. There were no significant differences or trends between the groups on how well clients liked their therapists, and on the average clients reported some disliking and some liking (dropout M = 2.35, non-dropout M = 1.78).

One-Way ANOVAs Of The Four Length Of Stay/Outcome Groups

There were 11 four-group comparisons made under the category Characteristics of Treatment and of these only three were significant at the .05 level or less. As such, 18 pair-wise comparisons were made (six per significant variable), using the Duncan's procedure, and only four of these were found significant at the .05 level or less. The short-term/unimproved group reported greater presenting psychological distress than the short-term/improved group on two variables, and the long-term/improved group reported greater presenting psychological distress than the short-term/improved group on two variables.

These results suggest that, for the category Characteristics of Treatment, there are few differences between the length of stay/outcome groups, and those that there are seem to be a function of the uniqueness of the short-term/improved group in their reports of less initial psychological distress. See Appendix F for these one-way analyses of variance.

Two-Way ANOVAs Of Length Of Stay And Outcome

The *t*-test analyses showed that dropouts were significantly different from non-dropouts on only one followup variable under the category Characteristics of Treatment, and Table 7 presents the results of the 2 by 2 ANOVA on this variable. For the question "How did your therapist feel about you as a person?", a main effect for outcome was found, $F(1,47) = 3.96$, $p = .053$, indicating that clients rated as unimproved at termination felt less liked by their therapists than clients rated as improved at termination.

Summary

There were no significant differences between dropouts and non-dropouts on variables in this category. There was a trend suggesting that dropouts felt less liked by their therapists than non-dropouts, although both groups on the average reported at least some liking. A two-way analysis of variance of this variable indicated that clients rated as unimproved felt less liked than clients rated as improved. This result suggests that the difference between dropouts and non-dropouts in therapist liking is a function of the main effect of outcome and not the uniqueness of the dropout group per se. One-way analyses of variance of the variables in this category revealed few differences among the four length of stay/outcome groups. Those that there were showed dropouts (short-term/unimproved clients) and long-term/improved clients as having presented with greater psychological difficulty at the beginning of treatment than short-term/improved clients.

TABLE 7

TWO-WAY ANOVAS OF LENGTH OF STAY AND OUTCOME ON CHARACTERISTICS OF TREATMENT

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p	Direction
How did your therapist feel about you as a person?	2.00	2.00	1.70	1.36	LOS	1.47	1,44	.232	
					OUT	3.96	1,44	.053	UNIMP>IMP
					LOSxOUT	.59	1,44	.455	

[a]The higher the mean score, the less the degree of liking. For the specific range and values of this question, see Appendix E.

Assumption: Dropouts Are Lost To Treatment Forever

The t-Test Comparisons Between Dropouts And All Other Former Clients

Table 8 presents the results of *t*-tests comparing dropouts to non-dropouts on the eight variables categorized under the assumption "Dropouts Are Lost To Treatment Forever." Only one significant difference was found between the groups: Dropouts reported that it was their decision to stop therapy more often than non-dropouts (*M*s = 1.79 and 1.33, respectively; $t(60) = 3.20$, $p = .002$). No differences were found, however, between the groups on other specific sources of termination (therapist decision, mutual agreement, or external factors).

Of the 58 clients who responded to an open-ended question asking for the reasons therapy was terminated, 5% said they terminated because they disliked treatment, 21% said they disliked their therapists, 7% reported they stopped because of a clinic time limit, 33% terminated because they felt better, 10% reported time and/or money constraints, 5% had their therapists leave the clinic, 7% moved, 7% stopped therapy at the clinic but continued in private therapy, and 5% reported feeling either fear of treatment or no motivation for it. A Chi-square analysis of the data revealed no differences between the groups on these reasons for termination, $X^2(9) = 10.49$, $p = .31$.

Results indicated that approximately one-half of each group consulted a mental health or non-mental health professional in connection with emotional problems since terminating treatment at the clinic, and for those clients who reentered therapy, one-half of each group did so

TABLE 8

THE t-TESTS COMPARING DROPOUTS TO NON-DROPOUTS ON THE ASSUMPTION "DROPOUTS ARE LOST TO TREATMENT FOREVER"

Followup Question	Means[a] Dropouts	Non-Dropouts	t	df	p
Why did you stop therapy?					
My decision	1.79	1.33	3.20	60	.002
My therapist's decision	1.00	1.15	-1.52	60	.134
Mutual agreement	1.14	1.38	-1.64	60	.105
External factors	1.07	1.15	- .72	60	.473
Have you consulted a physician, psychiatrist, psychologist, social worker, clergy, or anyone else in connection with emotional problems since terminating your therapy at KWC?	1.50	1.46	.26	62	.795
If you reentered therapy, was it for the same problems that led you to seek therapy at KWC?	1.43	1.60	- .55	25	.586
Since terminating therapy at KWC, have you ever felt a need for further treatment to deal with your problems?	3.07	2.85	.61	60	.545
At the present time, how much do you feel you need further therapy to deal with your problems?	2.00	2.06	- .19	62	.851

[a]With the exception of two questions ("Why did you stop therapy?" and "If you reentered therapy...?"), the higher the mean score, the greater the degree of psychological discomfort or need. For ranges and values of specific questions, see Appendix E.

on the average for either the same problems or for both some of the same plus some different problems.

Both dropouts and non-dropouts reported, on the average, to have felt the need for further treatment to deal with problems several times since terminating treatment at the clinic (Ms = 3.07 and 2.85, respectively; $t(60) = .61$, $p = .545$), and on the average reported experiencing a slight need for further therapy to help deal with problems at time of followup (Ms = 2.00 and 2.06, respectively; $t(62) = -.19$, $p = .851$).

A Chi-square analysis was used to determine if dropouts differed from non-dropouts in their reasons for not reentering treatment given a felt need for it. No significant differences were found, however, $X^2(5) = 5.83$, $p > .05$. Of the 29 clients who responded to this question, the following reasons were given for not reentering therapy: self-sufficiency (31%), external factors such as time and/or money constraints (41%), fear of treatment (7%), felt therapy couldn't help (3%), and a bad prior therapy experience (3%). Fourteen percent of the responses were not classifiable.

One-Way ANOVAs Of The Four Length Of Stay/Outcome Groups

There were eight four-group comparisons made under the category "Dropouts Are Lost To Treatment Forever" and of these only one was significant at the .05 level or less. As such, six pair-wise comparisons were made using the Duncan's procedure and only one of these was found significant at the .05 level or less: the short-term/unimproved group decided to terminate treatment more often than the long-term/improved group.

These results suggest that, for the assumption "Dropouts Are Lost To Treatment Forever," no group is uniquely different from any other group, with the exception of the client source of termination variable. See Appendix F for these one-way analyses of variance.

Two-Way ANOVAs Of Length Of Stay And Outcome

The t-test analyses indicated that dropouts were significantly different from non-dropouts on only one followup variable under the category "Dropouts Are Lost To Treatment Forever," and Table 9 presents the results of the 2 by 2 ANOVA on this variable. For the variable "Why did you stop therapy? My decision," a main effect for outcome was found, $F(1,58) = 4.81$, $p = .032$, indicating that clients rated as unimproved at termination decided to terminate treatment themselves more frequently than clients rated as improved.

Summary

Only one significant difference was found between the dropout and non-dropout groups on variables in this category. Dropouts reported that it was their decision to stop treatment more frequently than non-dropouts. A two-way analysis of variance of the variable "Why did you stop therapy: My decision" indicated that clients rated as unimproved initiated termination themselves more frequently than improved clients. This result suggests that the difference between the dropout and non-dropout groups on frequency of client-initiated terminations is a function of the main effect of outcome and not the uniqueness of the

TABLE 9

TWO-WAY ANOVAS OF LENGTH OF STAY AND OUTCOME ON THE ASSUMPTION "DROPOUTS ARE LOST TO TREATMENT FOREVER"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p	Direction
Why did you stop therapy?									
My decision	1.79	1.50	1.43	1.27	LOS	2.15	1,58	.148	
					OUT	4.81	1,58	.032	UNIMP>IMP
					LOSxOUT	.17	1,58	.686	

[a]Range = 1 to 2; No = 1/Yes = 2.

dropout group per se. One-way analyses of variance of the variables in this category revealed no basic differences between the four length of stay/outcome groups, except on the client source of termination variable which showed that dropouts (short-term/unimproved clients) self-terminated more frequently than long-term/improved clients.

Assumption: Dropouts Gain Nothing From Their Brief Treatment Contacts The t-Test Comparisons Between Dropouts And All Other Former Clients

Table 10 presents the results of t-test comparisons between dropouts and non-dropouts on the 43 variables categorized under the assumption "Dropouts Gain Nothing From their Brief Treatment Contacts." A number of significant differences and trends were found between the groups.

There was a trend indicating that dropouts overall felt less positive change as a result of therapy than non-dropouts, $t(62) = 2.24$, $p = .029$. On the average, dropouts reported that therapy either did not change them or it changed them somewhat for the better ($M = 2.50$), whereas non-dropouts reported on the average that therapy changed them somewhat for the better ($M = 1.98$).

In terms of the effect of therapy on the specific symptoms or problems that brought them to the clinic, there were trends indicating that dropouts rated their therapy as less helpful with Symptom/Problem A than non-dropouts (Ms = 2.38 and 1.78, respectively; $t(60) = 2.34$, $p = .022$), and less helpful with Symptom/Problem B than non-dropouts (Ms = 2.18 and 1.64, respectively; $t(48) = 2.05$, $p = .046$). There were no

TABLE 10

THE t-TESTS COMPARING DROPOUTS TO NON-DROPOUTS ON THE ASSUMPTION "DROPOUTS GAIN NOTHING FROM THEIR BRIEF TREATMENT CONTACTS"

Followup Question	Means[a] Dropouts	Non-Dropouts	t	df	p
Overall, how do you feel you have changed as a result of your psychotherapy at KWC?	2.50	1.98	2.24	62	.029
In what way did your therapy at KWC help or not help you with each of these problems or symptoms?					
Symptom/Problem A	2.38	1.78	2.34	60	.022
Symptom/Problem B	2.18	1.64	2.05	48	.046
Symptom/Problem C	2.71	1.97	1.77	36	.084
Symptom/Problem D	3.00	2.00	1.74	21	.096
In what way did your therapy at KWC help or not help you to deal with each of these problem areas?					
Problem Area A	2.33	1.82	1.75	55	.088
Problem Area B	2.11	1.91	.60	39	.550
Problem Area C	2.40	1.67	1.56	27	.129
Problem Area D	2.50	1.64	1.89	16	.077
Please describe what positive and negative changes you have experienced as a result of your psychotherapy at KWC?	1.75	1.38	1.71	55	.094
Since terminating therapy at KWC, what kind of effect would you say therapy had on your relationships with other people?	2.64	1.94	3.14	62	.003

Table 10 -- Continued

Followup Question	Means[a] Dropouts	Non-Dropouts	t	df	p
In what way has your therapy at KWC made a difference in the way you relate to the following people in your life?					
Mother	2.77	2.24	2.97	40.22[b]	.005
Father	2.91	2.39	3.10	36.85[b]	.004
Brothers/sisters	2.71	2.27	2.49	41.32[b]	.017
Other family members	2.69	2.43	1.12	51	.268
Boss/teacher	2.75	2.18	2.04	55	.046
Friends of same sex	2.86	2.16	4.54	50.12[b]	.002
Friends of opposite sex	2.86	2.38	3.31	45.60[b]	.002
Spouse	2.63	2.00	1.49	23	.149
Boyfriend/girlfriend	2.78	2.13	2.06	37	.046
Your children	2.50	1.93	1.45	19	.163
In what way has your therapy at KWC made a difference in the way you perform in the following areas?					
Parent	2.00	1.93	.15	18	.881
Wife/husband	2.43	2.35	.20	25	.844
Girlfriend/boyfriend	2.88	2.11	3.60	29.77[b]	.001
Work/career/education	2.77	2.11	3.84	38.41[b]	.000
Homemaker	2.69	2.57	.56	58	.578
Community/church member	2.88	2.72	.63	42	.531
Friend with same sex	2.85	2.22	3.89	45.59[b]	.000
Friend with opposite sex	2.83	2.34	3.05	37.58[b]	.004
Daughter/son	2.77	2.36	2.21	41.69[b]	.032
How much do you feel your therapy at KWC has or has not helped you to cope with new problems or symptoms that have arisen.	2.43	2.00	1.73	62	.088

Table 10 -- Continued

Followup Question	Means[a] Dropouts	Non-Dropouts	t	df	p
How would you say that your past therapy has or has not helped you to deal with these stressful events as they came up?					
Event A	2.67	1.98	2.35	58	.022
Event B	2.75	2.09	2.59	55	.012
Event C	2.56	2.11	1.40	42	.168
What did you get out of your therapy at KWC?					
Relief from unpleasant feelings or tensions.	2.21	1.70	-2.21	59	.031
Deeper understanding of the reasons behind my feelings and behavior.	2.21	1.78	-1.91	61	.060
Confidence to try new things, to be a different kind of person.	2.71	1.94	-4.57	36.81[b]	.000
Learned what my feelings were and what I really wanted.	2.57	2.04	-2.52	61	.014
Learned better self control over my moods and actions.	2.50	2.04	-2.23	60	.029
Worked out a particular problem that was bothering me.	2.50	1.83	-2.75	60	.008
Felt better about self as a person.	2.57	1.78	-3.52	61	.001
Got relief from bodily aches and pains.	2.79	2.49	-1.30	57	.198

Table 10 -- Continued

Followup Question	Means[a] Dropouts	Non-Dropouts	t	df	p
Everything considered, how satisfied are you with the results of your therapy at KWC?	3.50	2.40	2.10	62	.040

[a]The higher the mean score, the greater the dissatisfaction or lack of positive change. Mean scores for categories under the question "What did you get out of your therapy at KWC?" have been reflected to provide continuity in direction of value within the table. For ranges and values of specific questions, see Appendix E.

[b]The t values, degrees of freedom and significance levels of these variables were based upon separate variance estimates due to heterogeneity of variance.

significant differences between the groups on ratings of treatment effect on Symptom/Problem C and D, or on Problem Areas A, B, C, and D. On the average, client ratings ranged between being helped a great deal to therapy having made no difference (group Ms ranged between 1.64 and 3.00).

As to the number of changes, positive or negative, that clients attributed to their treatments, there were no differences between dropouts and non-dropouts (Ms = 1.75 and 1.38, respectively; $t(55) = 1.71$, $p = .094$. On the average, the groups tended to report positive or positive plus negative changes as a result of therapy, as opposed to only negative changes.

Dropouts significantly differed from non-dropouts in their ratings of the effects of therapy on relationships. In response to a question about the global effect of therapy on their relationships, dropouts reported therapy as having less positive effect than non-dropouts, $t(62) = 3.14$, $p = .003$. On the average, dropouts reported therapy as either having no impact on their relationships to somewhat improving them ($M = 2.64$). In contrast, the non-dropout group reported, on the average, that therapy either somewhat improved their relationships to greatly improved them ($M = 1.94$).

In response to questions about the impact of treatment upon specific relationships, the following results were obtained: There were no significant differences or trends between the dropout and non-dropout groups in their reports of treatment impact upon relationships with

other family members, spouses, or with their children. Group means ranged between 1.93 and 2.69, indicating that on the average overall ratings were between therapy slightly improving these relationships to therapy making no difference.

There were significance differences, however, between dropouts and non-dropouts in their reports on relationships with their mothers (*M*s = 2.77 and 2.24, respectively; *t*(40.22) = 2.97, *p* = .005), fathers (*M*s = 2.91 and 2.39, respectively; *t*(36.85) = 3.10, *p* = .004), friends of same sex (*M*s = 2.86 and 2.16, respectively; *t*(50.12) = 4.54, *p* = .002), and friends of opposite sex (*M*s = 2.86 and 2.38, respectively; *t*(45.60) = 3.31, *p* = .002). There were also trends indicating differences between dropouts and non-dropouts on relationships with brothers/sisters (*M*s = 2.71 and 2.27, respectively; *t*(41.32) = 2.49, *p* = .017), boss/teacher (*M*s = 2.75 and 2.18, respectively; *t*(55) = 2.04, *p* = .046), and boy-friend/girlfriend (*M*s = 2.78 and 2.13, respectively; *t*(37) = 2.06, *p* = .046). Taken together, these results indicated that on the average dropouts reported that therapy made no difference in these specific relationships, whereas for non-dropouts therapy slightly improved the way they related to these people on the average.

Regarding role performance, dropouts reported therapy as less positively influential in the following areas of their lives than non-dropouts: as a girlfriend/boyfriend (*M*s = 2.88 and 2.11, respectively; *t*(29.77) = 3.60, *p* = .001), in work/career/education (*M*s = 2.77 and 2.11, respectively; *t*(38.41) = 3.84, *p* = .000), as a friend with same

sex (*Ms* = 2.85 and 2.22, respectively; *t*(45.59) = 3.89, *p* = .000), and as a friend with opposite sex (*Ms* = 2.83 and 2.34, respectively; *t*(37.58) = 3.05, *p* = .004). There was also a trend indicating that dropouts rated therapy as having less impact than non-dropouts on the performance of their role as daughter/son (*Ms* = 2.77 and 2.36, respectively; *t*(41.69) = 2.21, *p* = .032). For dropouts, therapy tended to not make a difference in these relationships, whereas for non-dropouts therapy tended to slightly improve them.

In their role as parent, there were no differences between the groups and on the average therapy was reported as slightly improving parenting (dropout *M* = 2.00 and non-dropout *M* = 1.93). There were no differences found between the groups in the roles of wife/husband, homemaker, and community/church member, and on the average therapy was reported as either making no difference or slightly improving role performance (group *Ms* ranged from 2.88 to 2.35).

There were no differences between dropouts and non-dropouts in global ratings of degree of treatment effect upon their ability to cope with new problems or symptoms (*Ms* = 2.43 and 2.00, respectively; *t*(62) = 1.73, *p* = .008) and, on the average, the group reports ranged from therapy making no difference to providing some help. In terms of treatment impact upon client ability to deal with specific stressful events since termination, dropouts reported less help than non-dropouts (*Ms* = 2.78 and 2.09, respectively; *t*(55) = 2.59, *p* = .012) on one event (Event B). There was a trend for Event A in the same direction indicating that

dropouts felt less help from therapy than non-dropouts (*Ms* = 2.67 and 1.98, respectively; *t*(58) = 2.35, *p* = .022). As a group, dropout responses tended to average between treatment having no impact upon ability to deal with stressful events to helping a little, whereas non-dropout responses tended to average around therapy helping a little. There were no significant differences or trends between the groups on stressful Event C.

Analysis of the question "What did you get out of your therapy at KWC?" yielded a number of significant differences and trends between the groups. (Note: Mean scores for categories under this question have been reflected to provide continuity in direction of value among all the variables.) Dropouts reported receiving significantly less benefit from therapy than non-dropouts in the following ways: less confidence to try new things (*Ms* = 2.71 and 1.94, respectively; *t*(36.81) = -4.57, *p* = .000), less learning about what feelings really were (*M* = 2.57 and 2.04, respectively; *t*(61) = -.52, *p* = .014), less working out of a particular problem (*Ms* = 2.50 and 1.83, respectively; *t*(60) = -2.75, *p* = .008), and less feeling better about self as a person (*Ms* = 2.57 and 1.78, respectively; *t*(61) = -3.52, *p* = .001). The following trends also indicated that dropouts received less benefit from therapy than non-dropouts in the following ways: less relief from unpleasant feelings or tensions (*Ms* = 2.21 and 1.70, respectively; *t*(59) = -2.21, *p* = .031), and less learning of self control over moods and actions (*Ms* = 2.50 and 2.04, respectively; *t* (60) = -2.23, *p* = .029). Overall, dropouts as a group

felt, on the average, that they got between "none" and "some" (in contrast to "a lot") from therapy. Non-dropouts, on the other hand, reported that, on the average, they got "some" (in contrast to "none" or a lot") from therapy. There were no significant differences or trends between the groups on getting a deeper understanding of the reasons behind feelings and behavior or on getting relief from bodily aches and pains. Group means ranged between 2.79 and 1.78, indicating reports of getting "nothing" to getting "a lot."

Regarding client satisfaction with therapy, there was a trend indicating that dropouts felt less satisfied than non-dropouts, $t(62) = 2.10$, $p = .040$. On the average, dropouts reported slight dissatisfaction to slight satisfaction ($M = 3.50$), whereas non-dropouts reported slight to moderate satisfaction with therapy ($M = 2.40$).

One-Way ANOVAs Of The Four Length Of Stay/Outcome Groups

There were 43 four-group comparisons made under the assumption "Dropouts Gain Nothing From Their Brief Treatment Contacts" and of these 30 were significant at the .05 level of less. As such, 180 pair-wise comparisons were made between specific groups (six per significant variable), using the Duncan's procedure, and 49 of these were found significant at the .05 level of less. The short-term/unimproved group reported less treatment helpfulness and satisfaction than the long-term/improved group on 24 variables. The long-term/unimproved group reported less treatment helpfulness and satisfaction than the long-term/improved group on 13 variables, and the short-term/improved group reported less

treatment helpfulness and satisfaction than the long-term/improved group on 12 variables.

These results suggest that, for the assumption "Dropouts Gain Nothing From Their Brief Treatment Contacts," there are definite differences between specific groups, and these differences are a function of the uniqueness of the long-term/improved group in their positive reports of treatment helpfulness and satisfaction. See Appendix F for these one-way analyses of variance.

Two-Way ANOVAs Of Length Of Stay And Outcome

The t-test analyses indicated that dropouts significantly differed from non-dropouts on 25 followup variables under the assumption "Dropouts Gain Nothing From Their Brief Treatment Contacts," and Table 11 presents the results of 2 by 2 ANOVAs on these variables.

For the question "Overall, how do you feel you have changed as a result of your therapy at KWC?" a main effect for length of stay was found, $F(1,60) = 5.61$, $p = .021$, indicating that short-term clients reported less positive change as a result of therapy than long-term clients. In terms of the degree of help obtained from therapy on specific presenting symptomatology, results indicated that for Symptom/Problem A, short-term clients reported less positive effect than long-term clients, $F(1,58) = 5.00$, $p = .029$), and unimproved clients reported less positive effect than improved clients, $F(1,58) = 2.86$, $p = .096$. For Symptom/Problem B, the main effect for outcome which indicated that unimproved clients reported less positive effect than improved clients,

TABLE 11

TWO-WAY ANOVAS OF LENGTH OF STAY AND OUTCOME ON THE ASSUMPTION "DROPOUTS GAIN NOTHING FROM THEIR BRIEF TREATMENT CONTACTS"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p	Direction
Overall, how do you feel you have changed as a result of your psycho-therapy at KWC?	2.50	2.40	2.36	1.74	LOS	5.61	1,60	.021	Short>Long
					OUT	2.45	1,60	.123	
					LOSxOUT	1.33	1,60	.253	
In what way did your therapy at KWC help or not help you to deal with each of these problems?									
Symptom/ Problem A	2.38	2.20	2.14	1.53	LOS	5.00	1,58	.029	Short>Long
					OUT	2.86	1,58	.096	UNIMP>IMP
					LOSxOUT	.74	1,58	.393	
Symptom/ Problem B	2.18	2.50	2.00	1.41	LOS	1.62	1,46	.210	
					OUT	5.29	1,46	.026	UNIMP>IMP
					LOSxOUT	3.28	1,46	.077	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP
Since terminating therapy at KWC, what kind of effect would you say therapy had on your relationships with other people?	2.64	2.40	2.14	1.77	LOS	2.83	1,60	.098	
					OUT	6.46	1,60	.014	UNIMP>IMP
					LOSxOUT	.08	1,60	.778	

Table 11 -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p	Direction
In what way has your therapy experience made a difference in the way you relate to the following people in your life?									
Mother	2.77	2.80	2.31	2.08	LOS	.45	1,51	.504	
					OUT	5.74	1,51	.020	UNIMP>IMP
					LOSxOUT	.28	1,51	.597	
Father	2.91	2.22	2.57	2.33	LOS	2.02	1,35	.164	
					OUT	.70	1,35	.409	
					LOSxOUT	.42	1,35	.522	
Brothers/ sisters	2.71	2.50	2.38	2.18	LOS	.82	1,55	.370	
					OUT	1.72	1,55	.195	
					LOSxOUT	.00	1,55	.988	
Boss/teacher	2.75	3.00	2.50	1.93	LOS	2.19	1,53	.145	
					OUT	4.39	1,53	.041	UNIMP>IMP
					LOSxOUT	2.24	1,53	.140	
Friends of same sex	2.86	2.40	2.69	1.90	LOS	12.85	1,59	.001	Short>Long
					OUT	1.99	1,59	.164	
					LOSxOUT	.60	1,59	.441	
Friends of opposite sex	2.86	2.80	2.57	2.23	LOS	2.07	1,60	.156	
					OUT	3.88	1,60	.054	UNIMP>IMP
					LOSxOUT	.49	1,60	.488	
Boyfriend/ girlfriend	2.78	2.50	2.13	2.06	LOS	.23	1,35	.634	
					OUT	3.41	1,35	.073	UNIMP>IMP
					LOSxOUT	2.74	1,17	.116	

Table 11 -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p	Direction
In what way has your therapy at KWC made a difference in the way you perform in the following areas?									
Girlfriend/ boyfriend	2.88	2.75	2.43	1.81	LOS	2.57	1,31	.119	
					OUT	5.48	1,31	.026	UNIMP>IMP
					LOSxOUT	.73	1,31	.401	
Work/career/ education	2.77	2.75	2.62	1.80	LOS	9.53	1,56	.003	Short>Long
					OUT	3.93	1,56	.052	UNIMP>IMP
					LOSxOUT	3.02	1,56	.088	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP
Friend with same sex	2.85	2.60	2.69	1.97	LOS	8.40	1,58	.005	Short>Long
					OUT	2.43	1,58	.125	
					LOSxOUT	1.23	1,58	.294	
Friend with opposite sex	2.83	2.80	2.64	2.13	LOS	3.64	1,58	.062	
					OUT	2.93	1,58	.092	UNIMP>IMP
					LOSxOUT	1.11	1,58	.296	
Daughter/son	2.77	2.80	2.58	2.14	LOS	1.66	1,48	.203	
					OUT	2.43	1,48	.126	
					LOSxOUT	.94	1,48	.336	

Table 11 -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p	Direction
How would you say that your therapy has or has not helped you to deal with these stressful events as they came up?									
Event A	2.67	2.75	2.29	1.73	LOS	2.67	1,56	.108	
					OUT	4.87	1,56	.031	UNIMP>IMP
					LOSxOUT	1.23	1,56	.273	
Event B	2.75	3.00	2.50	1.83	LOS	5.97	1,53	.018	Short>Long
					OUT	3.31	1,53	.075	UNIMP>IMP
					LOSxOUT	2.35	1,53	.132	
What did you get out of your therapy at KWC?									
Relief from unpleasant feelings or tensions.	2.21	2.40	1.92	1.48	LOS	1.62	1,57	.209	
					OUT	6.01	1,57	.017	UNIMP>IMP
					LOSxOUT	1.96	1,57	.167	
Confidence to try new things, to be a different kind of person.	2.71	2.80	2.08	1.44	LOS	1.22	1,59	.274	
					OUT	14.68	1,59	.000	UNIMP>IMP
					LOSxOUT	.96	1,59	.331	
Learned what my feelings were and what I really wanted.	2.57	2.20	2.23	1.94	LOS	2.68	1,59	.107	
					OUT	2.22	1,59	.142	
					LOSxOUT	.03	1,59	.859	

Table 11 -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p	Direction
Learned better self-control over my actions.	2.50	2.40	2.46	1.80	LOS	8.11	1,58	.006	Short>Long
					OUT	1.85	1,58	.179	
					LOSxOUT	2.11	1,58	.152	
Worked out a particular problem that was bothering me.	2.50	2.60	2.00	1.63	LOS	1.18	1,58	.282	
					OUT	8.82	1,58	.004	UNIMP>IMP
					LOSxOUT	.98	1,58	.326	
Felt better about myself as a person.	2.57	2.60	1.68	2.08	LOS	4.26	1,59	.043	Short>Long
					OUT	12.52	1,59	.001	UNIMP>IMP
					LOSxOUT	1.97	1,59	.165	
Everything considered, how satisfied are you with the results of your therapy at KWC?	3.50	3.80	3.21	1.81	LOS	4.50	1,60	.038	Short>Long
					OUT	3.82	1,60	.055	UNIMP>IMP
					LOSxOUT	7.78	1,60	.088	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP

Note. Interactions with p values of .10 of less were probed using the Duncan's procedure (at a .05 level of significance).

[a]The higher the mean score, the greater the dissatisfaction or lack of positive change. Mean scores for categories under the question "What did you get out of your therapy at KWC?" have been reflected to provide continuity in direction of value within the table. For ranges and values of specific questions, see Appendix E.

$F(1,46) = 5.29$, $p = .026$, is tempered by the interaction effect that indicated that long-term/improved clients reported greater improvement on this symptom than each of the other three groups, $F(1,46) = 3.28$, $p = .077$. The other three groups did not differ from each other on this variable.

For therapeutic effect upon the way clients relate to specific people in their lives, 2 by 2 ANOVAs on the following relationships showed a main effect for outcome indicating that unimproved clients reported less positive effect than improved clients: mother, $F(1,51) = 5.74$, $p = .020$; boss/teacher, $F(1,53) = 4.39$, $p = .041$; friend of opposite sex, $F(1,60) = 3.88$, $p = .054$; and boyfriend/girlfriend, $F(1,35) = 2.74$, $p = .073$. Regarding relationships with friends of the same sex, a main effect was found for length of stay indicating that short-term clients reported less positive effect than long-term clients, $F(1,59) = 12.85$, $p = .001$.

For therapeutic effect upon role performance as a girlfriend/boyfriend and friend with the opposite sex, results indicated main effects for outcome in which unimproved clients reported less positive effect from therapy than improved clients, $F(1,31) = 5.48$, $p = .026$ and $F(1,58) = 2.93$, $p = .092$, respectively. For relationships with friends of the same sex, results indicated a main effect for length of stay with short-term clients reporting less positive effect from therapy on role performance than long-term clients, $F(1,58) = 8.40$, $p = .005$. In the work/career/education role, results indicated a main effect for length

of stay in which short-term clients reported less positive effect than long-term clients, $F(1,56) = 9.53$, $p = .003$, a main effect for outcome in which unimproved clients reported less positive effect than improved clients, $F(1,56) = 3.93$, $p = .052$, and an interaction effect in which the long-term/improved group reported therapy as positively improving their role performance significantly more than each of the other three groups, $F(1,56) = 3.02$, $p = .088$.

Dropouts were significantly different from non-dropouts on the question "How would you say that your therapy has or has not helped you to deal with these stressful events as they came up? Event A and Event B." The analyses of variance of Event A indicated a main effect for outcome in which unimproved clients reported less positive effect than improved clients, $F(1,56) = 4.87$, $p = .031$. For Event B, results indicated a main effect for outcome with unimproved clients reporting less positive effect than improved clients, $F(1,53) = 3.31$, $p = .075$, and a main effect for length of stay with short-term clients reporting less positive effect than long-term clients, $F(1,53) = 5.97$, $p = .018$.

Dropouts were different from non-dropouts on six of the eight specific benefits listed under the question "What did you get out of your therapy at KWC?" Analyses of variance indicated a main effect for outcome on the following specific benefits in which unimproved clients reported getting less than improved clients: relief from unpleasant feelings or tensions, $F(1,57) = 6.01$, $p = .017$; confidence to try new things, to be a different kind of person, $F(1,59) = 14.68$, $p = .000$; and

the chance to work out a particular problem, $F(1,58) = 8.82$, $p = .004$. In terms of feeling better about the self as a person, a main effect for outcome was found in which unimproved clients reported getting less than improved clients, $F(1,59) = 12.52$, $p = .001$, and a main effect for length of stay was found in which short-term clients reported getting less than long-term clients, $F(1,59) = 4.26$, $p = .043$). As to learning better self-control over actions, a length of stay main effect was found indicating that short-term clients reported less benefit than long-term clients, $F(1,58) = 8.11$, $p = .006$.

In terms of global satisfaction with treatment, there were main effects for length of stay in which short-term clients were less satisfied than long-term clients, $F(1,60) = 4.50$, $p = .038$, and for outcome in which unimproved clients were less satisfied than improved clients $F(1,60) = 3,82$, $p = .055$. There was also an interaction effect that indicated the long-term/improved group was more satisfied than each of the other three groups, $F(1,60) = 7.78$, $p = .088$.

Summary

A number of significant differences and trends were found between the dropout and non-dropout groups on variables in this category. To sum, dropouts felt therapy had less positive impact overall, was less helpful with specific symptoms/problems brought to treatment, had less impact upon global and specific relationships and upon role performance, and was less helpful in dealing with stressful situations. Dropouts also felt they received less specific benefit from therapy than non-dropouts, and reported being less satisfied with their treatments.

Two-way analyses of variance of these variables revealed only three instances in which an interaction effect accounted for a significant portion of the variance between groups. The long-term/improved group reported more positive impact and satisfaction than each of the three other groups (dropouts -- short-term/unimproved, short-term/improved, and long-term/unimproved) on help with Symptom/Problem B, role performance in work/career/education, and satisfaction with treatment. These three other groups did not significantly differ from each other, however. The remaining analyses showed 13 main effects for outcome (with unimproved related to no therapeutic impact and/or less positive gain), and 7 main effects for length of stay (with short-term related to no therapeutic impact and/or less positive gain). These results suggest that the differences found between dropouts and non-dropouts with t-test analyses were more a function of the main effects of outcome and length of stay than the uniqueness of the dropout group per se.

One-way analyses of variance of the variables in this category revealed that there were definite differences between specific length of stay/outcome groups, and that these differences were a function of the uniqueness of the long-term/improved group who reported greater benefit, positive gain, and satisfaction with therapy than each of the other three groups. The other three groups did not differ from each other in their reports of less treatment helpfulness and satisfaction.

Assumption: Dropouts Remain Clinically Unchanged And In Psychological Need Following Termination

The t-Test Comparisons Between Dropouts And All Other Former Clients

Table 12 presents the results of *t*-tests comparing dropouts to non-dropouts on the 38 variables categorized under the assumption "Dropouts Remain Clinically Unchanged And In Psychological Need Following Termination." No trends and only one significant difference were found between the groups under this assumption. For the variable, Functioning Index, in which self-reported global current level of functioning was combined with self-reported global change as a result of therapy (with a scale range of 2 to 11), dropouts scored less well than non-dropouts (*M*s = 5.64 and 4.56, respectively; $t(62) = 2.56$, $p = .013$).

In response to the question "How well do you feel you are getting along, emotionally and psychologically, at this time?", both group reports ranged, on the average, from "so-so; manage to keep going with some effort" to "quite well; no important complaints." In terms of presenting symptomatology, both groups reported, on the average, moderate to no trouble at the time of followup (dropout *M* range = 1.92 to 2.33 and non-dropout *M* range = 1.69 to 2.05). For presenting problem areas, the groups reported, on the average, moderate to no difficulty at the present time (dropout *M* range = 1.60 to 2.17 and non-dropout *M* range = 1.69 to 2.08). Both groups also reported, on the average, a feeling of slight need for further treatment at the time of followup to deal with their problems (dropout *M* = 2.00, non-dropout *M* = 2.06).

TABLE 12

THE t-TESTS COMPARING DROPOUTS TO NON-DROPOUTS ON THE ASSUMPTION "DROPOUTS REMAIN CLINICALLY UNCHANGED AND IN PSYCHOLOGICAL NEED FOLLOWING TERMINATION"

Followup Question	Means[a] Dropouts	Non-Dropouts	t	df	p
Functioning Index: Getting along now + Changed as a result of therapy.	5.64	4.56	2.56	62	.013
How well do you feel you are getting along, emotionally and psychologically, at this time?	3.14	2.58	1.73	62	.089
How much are each of these symptoms or problems you listed above troubling to you at the present time?					
Symptom/Problem A	1.92	1.69	.85	60	.401
Symptom/Problem B	2.00	1.89	.39	49	.700
Symptom/Problem C	2.29	1.84	1.07	36	.290
Symptom/Problem D	2.33	2.05	.43	21	.670
How would you rate your ability to deal with these problem areas at the present time?					
Problem Area A	2.17	1.69	1.84	55	.072
Problem Area B	1.89	1.79	.33	40	.743
Problem Area C	1.60	2.08	-.96	28	.344
Problem Area D	2.00	1.73	.54	17	.594
At the present time, how much do you feel you need further therapy to deal with your problems?	2.00	2.06	-.19	62	.851

Table 12 -- Continued

Followup Question	Means[a] Dropouts	Non-Dropouts	t	df	p
Do you feel ill at ease or uncomfortable with other people now?	1.93	2.02	-.47	62	.642
How do you feel about the way you relate to each of the people listed below?					
Mother	2.15	1.86	.99	53	.325
Father	2.00	2.00	0.00	37	1.000
Brothers/sisters	1.86	1.65	1.00	58	.321
Other family members	2.00	1.73	1.01	52	.316
Friend of same sex	1.71	1.61	.44	61	.665
Friend of opposite sex	1.92	1.96	-.13	61	.901
Spouse	2.14	1.65	1.58	22	.128
Boyfriend/girlfriend	2.25	1.62	1.68	32	.101
Your children	2.25	1.63	1.46	18	.160
How do you feel you have been performing in these areas of your life?					
Parent	2.25	1.81	.99	18	.334
Wife/husband	2.14	1.71	1.13	22	.272
Girlfriend/boyfriend	1.88	1.89	-.04	33	.966
Work/career/education	2.15	1.78	1.30	60	.199
Homemaker	2.23	2.10	.48	59	.636
Community/church member	2.75	2.64	.24	42	.810
Friend with same sex	1.79	1.72	.28	62	.783
Friend with opposite sex	1.92	2.12	-.67	60	.508
Daughter/son	2.15	2.00	.62	52	.539

Table 12 -- Continued

Followup Question	Means[a] Dropouts	Non-Dropouts	t	df	p
Symptom/Problem change score from entry to present:					
Symptom/Problem A	-2.00	-2.14	.53	60	.595
Symptom/Problem B	-1.83	-1.79	-.13	49	.900
Symptom/Problem C	-1.43	-1.81	.87	36	.389
Symptom/Problem D	-1.33	-1.60	.35	21	.728
Problem Area change score from entry to present:					
Problem Area A	-1.33	-1.91	1.90	55	.063
Problem Area B	-1.44	-1.73	.81	40	.425
Problem Area C	-2.00	-1.44	-.93	28	.360
Problem Area D	-1.75	-1.73	-.03	17	.976

[a]The higher the mean score, the greater the psychological discomfort, difficulty, dissatisfaction, or felt need for therapy. For ranges and values of specific questions, see Appendix E.

As to relationships in general, on the average both groups reported feeling occasional discomfort with other people at time of followup (dropout $\underline{M}$ = 1.93 and non-dropout $\underline{M}$ = 2.02). For specific relationships (mother, father, brothers/sisters, other family members, boss/teacher, friend of same sex, friend of opposite sex, spouse, boyfriend/girlfriend, your children), group averages ranged from "very satisfied with myself" about relating to others to "somewhat dissatisfied with myself" (group $\underline{M}$ range = 1.63 to 2.25). For role performance as a parent, wife/husband, girlfriend/boyfriend, work/career/education, homemaker, community/church member, friend with same sex, friend with opposite sex, and daughter/son, group reports ranged on the average from ratings of "very well" to "so-so" (group $\underline{M}$ range = 1.71 to 2.75).

In terms of direction of change in presenting symptomatology and presenting problem areas between entry into treatment and time of followup, both groups reported changes for the better. Both groups also reported, on the average, the same degree of improvement in both symptomatology and ability to deal with problems (Symptom/Problem group $\underline{M}$ change score range = -1.33 to -2.14; Problem Area group $\underline{M}$ change score range = -1.33 to -2.00).

One-Way ANOVAs Of The Four Length Of Stay/Outcome Groups

There were 38 four-group comparisons made under the assumption "Dropouts Remain Clinically Unchanged And In Psychological Need Following Termination," and of these six were significant at the .05 level or less. As such, 36 pair-wise comparisons were made (six per significant

variable), using the Duncan's procedure, and of these 11 were found significant at the .05 level of less. The short-term/unimproved group reported getting along less well than the short-term/improved group on one variable, and less well than the long-term/improved group on one variable. The long-term/unimproved group reported getting along less well than the short-term/improved group on four variables, and less well than the long-term/improved group on four variables. And the short-term/improved group reported getting along better than the long-term/improved group on one variable.

These results suggest that, for the assumption "Dropouts Remain Clinically Unchanged And In Psychological Need Following Termination," there are some differences between specific length of stay/outcome groups, and those that do exist tend to be a function of the uniqueness of the long-term/unimproved group in terms of less satisfactory functioning and well-being at followup. See Appendix F for these one-way analyses of variance.

Two-Way ANOVAs Of Length Of Stay And Outcome

The dropout group was significantly different from the non-dropout group on only one followup variable categorized under the assumption "Dropouts Remain Clinically Unchanged And In Psychological Need Following Termination." Table 13 presents the results of the 2 by 2 ANOVA on the variable Functioning Index (a combination of the questions "How well do you feel you are getting along . . . at this time?" and "Overall, how do you feel you are changed as a result of your psychotherapy at

KWC?"). Results indicated a main effect for outcome in which unimproved clients were functioning less well than improved clients, $F(1,60) = 7.07$, $p = .010$.

Summary

Only one significant difference was found between the dropout and non-dropout groups on variables in this category. Dropouts did less well on the variable Functioning Index than non-dropouts. A two-way analysis of variance of this variable indicated a main effect for outcome, with unimproved clients doing less well than improved clients. This result suggests that the difference between the groups on Functioning Index is more a function of the main effect of outcome than the uniqueness of the dropout group per se.

One-way analyses of variance of the variables in this category revealed some differences between the four length of stay/outcome groups, and most of those were a function of the uniqueness of the long-term/unimproved group in their reports of less satisfactory functioning and well-being at followup.

TABLE 13

TWO-WAY ANOVAS OF LENGTH OF STAY AND OUTCOME ON THE ASSUMPTION "DROPOUTS REMAIN CLINICALLY UNCHANGED AND IN PSYCHOLOGICAL NEED FOLLOWING TERMINATION"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p	Direction
Functioning Index: Getting along now + Changed as a result of therapy.	5.64	5.60	4.64	4.35	LOS	.34	1,60	.563	
					OUT	7.07	1,60	.010	UNIMP>IMP
					LOSxOUT	.08	1,60	.773	

[a]The higher the mean score, the less the psychological well-being and benefit from treatment. For ranges and values of this variable, see Appendix E.

CHAPTER V

DISCUSSION

The purpose of this study was to empirically test the validity of the mental health professional's blanket assumption of treatment failure with psychotherapy dropouts using a revised operational definition of the term dropout and client self reported evaluations at time of followup.

Results support the use of a two-criterion (short length of stay/ negative outcome at termination) operational definition of dropout in clinical practice and research. The traditional short length of stay definition was found to indiscriminately group short-term clients who were clinically improved with short-term clients who were clinically unimproved.

The value and importance of considering psychotherapeutic phenomena from the client's perspective is confirmed by the fact that client reports provided information about treatment dropout that was heretofore either unknown, erroneously assumed, or evaluated differently from the professional's perspective.

Results do not support the mental health professional's assumption that dropouts reject psychotherapeutic treatment as a means to solve problems, nor do they support the assumption that dropouts remain clini-

cally unchanged and in psychological need following termination. Dropouts were also not found to be unique in terms of certain specific characteristics of treatment.

There is limited support for the professional's assumption that dropouts do not improve as a direct result of treatment for, on the average, dropouts reported either no treatment impact or slight positive effect. Dropout satisfaction with treatment also ranged from slight satisfaction to slight dissatisfaction. For the most part, however, differences in reports of treatment helpfulness were primarily due to kind of outcome (negative outcome was related to reports of less treatment helpfulness) and, at times, length of stay (short length of stay was related to reports of less treatment helpfulness). In addition, as a group, dropouts were not unique in their reports of less treatment helpfulness and satisfaction. Only the long-term/improved group of clients reported distinctly higher levels of treatment satisfaction and greater positive treatment effect.

The implications of these findings are discussed in detail below under the categories "Characteristics Of Treatment," the assumption that "Dropouts Are Lost To Treatment Forever," the assumption that "Dropouts Gain Nothing From Their Brief Treatment Contacts," and the assumption that "Dropouts Remain Clinically Unchanged And In Psychological Need Following Termination."

Characteristics Of Treatment

Considerable clinical and research effort has been expended upon investigations of descriptive and predictive variables related to treatment dropout. To date, however, no client demographic, therapist demographic, nor treatment variable has been consistently found to identify a particular class of clients who drop out of treatment or a particular class of therapists for whom client dropout is a problem. Results from this study are in line with these negative findings. Dropouts as a group were found to not differ from all other former clients on self-reported presenting degree of psychological distress and on client-therapist liking for each other, as experienced by the client.

There was some evidence to suggest that dropouts as well as long-term/improved clients were more troubled at treatment onset than short-term/improved clients. This finding suggested some interesting possibilities for understanding professional concern for the welfare of dropouts, and the professional's negative interpretation of dropping out of treatment.

Regarding professional concern for client welfare, one wonders whether or not the professional's perception of a client as behaviorally inconsistent or consistent, and therefore someone to be or not to be concerned about, is dependent upon the client's initial distress level in relation to the subsequent length of stay in treatment. The short-term/improved group of clients, for example, appeared to present a behaviorally consistent picture of themselves in that their short

lengths of stay in treatment were consistent with less initial distress. That is, short-term clients may have been short term because they did not perceive themselves as seriously troubled and did not, therefore, consider extensive therapy necessary. Therapist evaluations of improved outcome for these short-term clients also seemed consistent with the short-term/improved group's reports of less initial disturbance, for clients who are not seriously troubled at the beginning of treatment, and do not get worse over their brief stays, are likely to be evaluated by their therapists as improved. This interpretation is based upon the research of Keniston, et al. (1971), Mintz, (1972), and Green, et al. (1975) in which therapist ratings of global improvement were found to be made upon the basis of current level of functioning and not on the basis of actual amount of change during therapy. Professional attention and concern would not likely be drawn to such a consistent pattern of behavior associated with less distress.

The long-term/improved group of clients also seemed to present a behaviorally consistent picture of themselves in that they perceived themselves as seriously troubled at onset and continued in therapy for a professionally respectable length of time thereby giving the treatment an opportunity to work. While professional attention and concern for these clients may have been stimulated, given their initially high distress levels, it would also likely be quelled in that client and therapist were actively working together to remedy the client's difficulties.

Psychotherapy dropouts, on the other hand, seemed to present an inconsistent picture of themselves in that they reported themselves in great or greater psychological discomfort yet did not follow through with the recommended treatment plan. The fact that therapists rated their outcomes as unimproved further supports an impression of dropouts as behaviorally inconsistent. Professional attention would likely be drawn to dropouts given their high initial distress level, and concern for their welfare would likely be generated given their terminations in spite of presenting need.

It makes intuitive sense that behavioral inconsistency would serve as a red flag to mental health professionals in that there is an anomaly to be accounted for. In the case of dropouts, the anomaly or inconsistency is that these clients report in need but do not follow through with the recommended treatment plan. But what may look like inconsistent behavior may, with added information, be totally consistent. For example, professionals have tended to assume that a client's inconsistent behavior is an indicator of continued need, which in turn generates concern for client welfare. An alternative assumption that should be considered, however, is that dropouts have either resolved their distress or have chosen other means to do so, unbeknownst to their therapists.

Rather than responding to what on the surface seems to be inconsistent behavior with assumptions of continued need and concern for client welfare, therapists need to look beneath the surface and gather

information to establish the circumstances of treatment dropout on an individual, case by case basis, particularly as these circumstances relate to the client's state of psychological distress immediately post-termination and the client's plans to deal with presenting symptoms and problems. Individual therapists are encouraged to conduct their own brief and informal followups of clients who drop out of treatment with them to discern this important information.

The dropout's presentation of great or greater psychological discomfort may also be related to the professional's negative interpretation of dropping out of treatment. For example, it seems to make intuitive sense that the client's presenting degree of psychological distress stimulates the therapist's wish to be helpful, which in turn elicits the offer of psychotherapeutic service. In stopping treatment after a brief period of time, the client in effect does not permit gratification of the therapist's wish to help, at least in any conventional way that befits traditional psychotherapy. This lack of gratification can easily be seen to result in therapist frustration and/or disappointment, leaving the therapist vulnerable to feelings of anger, rejection, and devaluation. The question is raised as to what extent these difficult feelings are projected onto the phenomena of treatment dropout, thereby casting it in its current negative light.

The therapist's personal experience of treatment dropout may be a potentially significant issue in understanding psychotherapy dropout phenomena, and needs to be identified as an issue that is separate from

the issue of professional concern for the welfare of dropouts. Clinically, one wonders whether or not the therapist's experience of treatment dropout requires its own personal analysis and working through on a case by case basis.

With regard to client reported client-therapist liking for each other, there were no significant differences between dropouts and non-dropouts in their reports of like and dislike for therapists, although 21% of the sample reported terminating treatment because they did not like their therapists. So while clients do personally reject therapists, these results indicate that dropouts are not unique in this regard, and dropping out of treatment should not be interpreted as a direct or singular indicator of the client's personal rejection of the therapist.

Results did indicate that dropouts tended to report feeling less liked by their therapists than non-dropouts. This finding, however, is tempered by the finding that kind of outcome (improved/unimproved) accounted for a significant portion of the variance in this variable, with unimproved clients feeling less liked than improved clients. (It is important to note here that "less liked" does not mean "disliked," for clients in this sample reported on the average that their therapists had at least some positive sentiment towards them.)

The liking factor has been found by some researchers (e.g., Bent, Putnam, & Kiesler, 1976; Board, 1959; Lipkin, 1954; Ryan & Gizynski, 1971; Strupp, et al., 1969; Tovian, 1977) to be an important ingredient

in therapeutic process and outcome, and the finding of a positive relationship between outcome and degree of client felt liking by therapist supports this thesis. Dropping out of treatment should not, however, be interpreted as a direct indicator of client dislike of therapist. Furthermore, dropout status should not be interpreted as indicating client feelings of dislike by therapists. Given that dropouts are defined as short-term/negative outcome clients, and negative outcome is related to clients feeling less liked by their therapists, however, dropout status may be interpreted as indicating the client's experience of less therapist liking as compared to psychotherapy clients with positive outcomes.

Assumption: Dropouts Are Lost To Treatment Forever

Mental health professionals have generally assumed that psychotherapy dropouts self-initiate their terminations from treatment and in so doing reject psychotherapy as a means to solve their problems. Given this presumed rejection, professionals do not expect dropouts to seek psychotherapeutic treatment elsewhere, nor do they expect them to return for treatment at some future point in time. In other words, dropouts are presumed lost to treatment forever.

Results of this study do not support this assumption of blanket rejection of treatment by all psychotherapy dropouts. One-half of the dropout group reported going on for more help, reentry into treatment was reported for either some of the same or for some same and some different problems, and on the average the dropout group reported feeling a slight need for more treatment at time of followup.

In addition to finding that dropouts did not unanimously reject the idea of help from therapy, the post-termination treatment histories of dropouts were found to not differ from those of all other former psychotherapy clients. Dropouts were not different from non-dropouts on additional therapy after termination, reasons for reentry into treatment, nor on levels of felt need or desire for further therapy at time of followup. Dropouts were also not different from non-dropouts on their self-reported reasons for termination. In fact, the variety of client reasons for termination underscores the importance of understanding termination from therapy on an individual, case by case basis, in contrast to presuming cause of termination from length of stay or kind of outcome.

Results did indicate that dropouts self-initiated terminations more frequently than all other former therapy clients as a group, and more frequently than long-term/improved clients in particular. Dropouts cannot be flagged as a uniquely different group in terms of client-initiated sources of termination, however, for kind of outcome (improved/unimproved) accounted for a significant portion of the variance in the client-initiated source of termination variable, with unimproved clients initiating terminations more frequently than improved clients.

Interestingly, in support of a relationship between negative outcome and client-initiated terminations is information from clinic records that showed therapists reporting 100% of their clients with negative outcomes as self-terminated, but only 20% of their clients with

positive outcomes as self-terminated. Apparently, if a client is evaluated at termination as having a negative outcome, client and therapist are more likely to agree that the termination of treatment was client-initiated. If the outcome is positive, however, the therapist is likely to perceive termination of treatment as therapist-initiated and/or approved, but the client may evaluate termination as client-initiated, therapist-initiated, mutually initiated, or initiated for external reasons.

Taken together, these findings provide support for the notion that treatment termination needs to be understood on an individual, case by case basis, rather than presuming reasons for termination or post-termination treatment histories on the basis of length of stay, kind of outcome, or dropout classification status. The potential for differences between the views of the client and therapist is also evident in these results, thereby highlighting the value of using client as well as therapist self-report for a comprehensive understanding of treatment experience and outcome.

Assumption: Dropouts Gain Nothing From Their Brief Treatment Contacts

The traditional belief that lengthier treatments are necessary in order for desireable change to occur has led professionals to assume that psychotherapy dropouts gain nothing from their brief experiences in therapy. Results of this study provide only circumscribed support for this assumption however.

Gross comparisons of dropouts to all other former psychotherapy clients as a group showed that dropouts reported therapy as less helpful, as having less of an impact, and at times as having no effect upon an area in question. Dropouts were also found to report receiving less specific benefit from therapy, and to be less satisfied with their treatments than all others as a group.

In contrast to these findings, however, a detailed analysis of the effects of outcome and length of stay upon these treatment impact variables indicated that dropouts were not different from other specific groups of former clients in terms of gain from treatment. In fact, kind of outcome (unimproved/improved) and/or length of stay (short-term/long-term) accounted for significant portions of the variance in most of these variables. Unimproved clients reported less improvement, impact, and benefit than improved clients, and short-term clients reported less improvement, impact, and benefit than long-term clients. As such, while gross comparisons between dropouts and all other former clients indicated that dropouts gained less from treatment, a more in depth analysis suggested that differences in gain from treatment were due to factors related to the variables of outcome and/or length of stay and not as a function of dropout status per se.

In further contrast to the results of gross comparisons of dropouts to all other former clients, two different sets of findings suggested that when it comes to identifying a group of clients as unique in terms of gain from therapy and satisfaction with treatment, the psycho-

therapy dropout should not be flagged as lagging behind all other clients. In fact, the long-term/improved client seems to stand above all others in this regard. To wit, there were three exceptions to the main effect findings of the detailed analyses of the treatment impact variables. For the variables Change in Symptom/Problem B, Performance in Work/career/education, and Satisfaction with Treatment, the long-term/improved group of clients reported themselves as significantly more improved as a result of therapy and more satisfied with treatment than dropouts (short-term/unimproved clients), short-term/improved clients, and long-term/unimproved clients. In addition, in the set of analyses comparing the four length of stay/outcome groups to each other, results indicated that the long-term/improved group differed frequently from the other three groups of clients, yet these other three groups did not differ frequently from each other. The direction of these differences indicated that long-term/improved clients reported more gain from and satisfaction with treatment.

These two sets of findings also tentatively suggested specific relationships between each of the four length of stay/outcome groups and client reports of treatment helpfulness and satisfaction. The characteristic positive or negative experience of each group will be discussed below, along with speculation about each group's pretreatment expectations of help from therapy and the impact of those initial expectations upon subsequent treatment experience and continuation in therapy.

The long-term/improved group. Clients in the long-term/improved group tended to report therapy as helpful, and were distinctly satisfied with the treatments they received. The fact that their therapists rated them as improved at termination strengthens client reports of therapy as positive, and suggests that clients and therapists shared a rewarding experience.

Inasmuch as the pretherapy training literature suggests that continuation and progress in treatment are facilitated when client prognostic and role expectations are aligned with the reality of the treatment situation (Albronda, Dean, & Starkweather, 1964; Baum & Felzer, 1964; Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964; Jacobs, Charles, Jacobs, Weinstein, & Mann, 1972; Orne & Wender, 1968; Schonfield, Stone, Hoehn-Saric, Imber, & Pande, 1969; Warren & Rice, 1972), one wonders whether or not long-term/improved clients entered treatment with realistic expectations of psychotherapy, or had their expectations shaped naturally in the course of treatment. Their reported satisfaction with treatment suggests that their expectations of help from therapy were confirmed. In addition, their own and their therapists' reports of outcome as improved suggest that the nature of those expectations were realistic inasmuch as they were within the realm of possibility. Within the context of such a positive therapeutic experience, it makes sense that these clients had lengthier stays in treatment.

The short-term/improved group. Clients in the short-term/improved group represent a group of clients traditionally classified as psycho-

therapy dropouts. It is important to note that given their professionally evaluated status at termination as improved, they do not warrant the clinical concern that is in principle meant for clients who stay in treatment for only short periods of time but have not improved clinically at time of termination. It is also important to note that these clients, in seeming contrast to these professional evaluations of improved outcome, tended to report therapy on the average as unhelpful and reported marginal satisfaction/dissatisfaction with their treatments overall. Given this negative experience of therapy, it makes sense that short-term/improved clients stayed in treatment for only relatively brief periods of time.

The fact that the therapists of these clients rated them as improved at termination presents an interesting puzzle. On the surface it looks like these clients and therapists just basically disagreed about the helpfulness of therapy, thereby highlighting the importance of considering client as well as therapist evaluations of treatment. The possibility of basic agreement between these client and their therapists exists as well, however, given the nature of the followup and outcome measures used in this study. Specifically, the client followup measure asked clients for direct attributions of change due to therapy, but the professional outcome measure asked only for ratings of change per se. Consequently, clients could have reported that no change was due to therapy, yet have changed for the better during their brief courses of treatment. Therapists, on the other hand, could have observed this

improvement and evaluated clients as improved without implying change as a function of treatment.

Whether or not short-term/improved clients and their therapists shared a common view of therapy as unproductive cannot be determined from this data. It is a question of some importance, however, considering its clinical and economic implications. Clinically, for example, disagreement about the effectiveness of psychotherapy could represent an incongruence between client and therapist role expectations, or an incongruence between client expectations of help from therapy and the reality of what therapy has to offer. The fact that these clients reported, on the average, marginal satisfaction/dissatisfaction with treatment suggests that their expectations for help were not met. How realistic their expectations were, and how aligned they were with therapist expectations deserves serious clinical consideration and empirical investigation, considering the fact that research has shown incongruence in client and therapist role expectations and unrealistic client expectations of treatment to be related to shorter lengths of stay in treatment and lack of progress therein (see reviews by Garfield, 1978; Lorian, 1978; Murray & Jacobson, 1978).

Economically, the high incidence of short-term therapies has been used as grounds for the ineffectiveness of psychotherapy. The short-term/improved clients' reports of lack of treatment effect support this thesis, but the position of their therapists on this argument is not clear. From the administrative/economic point of view, it seems impor-

tant to consider the possibility that short-term/improved clients represent a class of psychotherapy clients that respond quickly in brief treatment situations, possibly due to placebo effects in the treatment process, the brief contact itself, or variables external to the treatment situation. Within the context of this improvement, however, it seems important to consider the additional possibility that the psychotherapeutic experience provided a kind of holding environment in which positive change, for whatever reason, could take place. Individual psychotherapy may not be the holding environment of choice; a group setting might make more sense, particularly from a cost-effective point of view. The data from this study do not, however, support the withdrawal of psychotherapeutic service from clients strictly on the basis of short length of stay. Further investigation of the therapist's understanding of the outcomes of short-term/improved clients is needed before any conclusions can be drawn about the impact of treatment with these clients.

Psychotherapy dropouts. Psychotherapy dropouts (short-term/unimproved clients) and their therapists did not disagree about the effects of treatment. Dropouts tended to report that they did not, for the most part, benefit from treatment and, on the average, reported marginal satisfaction/dissatisfaction with the service provided. Their therapists also evaluated them as unimproved at time of termination.

The fact that dropouts reported marginal satisfaction/dissatisfaction with treatment is contrary to literature that shows many dropouts

to be distinctly satisfied with their brief treatment contacts (e.g., Johansson, et al., 1980; Larsen, et al., 1979; Lebow, 1982; Littlepage, et al., 1976). At first glance, it seems that this discrepancy might be due to differences between the studies in their operational definitions of the term dropout. Specifically, the present study used a two-criterion definition of dropout (short length of stay and negative outcome at termination) whereas other studies generally defined dropout using a traditional short length of stay criterion alone. A methodological explanation for dropout dissatisfaction was ruled out, however, given the fact that the short-term/improved clients of this study, who traditionally are classified as dropouts, also reported on the average the same slight satisfaction/dissatisfaction with treatment.

It also seems conceivable that this discrepancy has something to do with differences in the lengths of the followup periods between studies. That is, the present study's followup period averaged around five years, in contrast to the one- to six-month followup periods of most satisfaction studies. As was discussed in the literature review section of this paper, the self report method is subject to many biases (to name a few, client desires to please, client concern for continued access to service, client need to justify entry or termination from therapy), but the influence of bias is thought to diminish with the passage of time. One wonders, therefore, whether or not dropouts in this study reported less satisfaction with treatment because the passage of time presented them with an opportunity to make judgments without undue influence from

internal or external pressures related to the experience in question. One further wonders whether or not the judgments of treatment satisfaction in this study were therefore more reasoned and accurate than those of other studies. They may also represent judgments that have simply been altered because of the instability of the variable of treatment satisfaction. The test-retest reliability of the variable of treatment satisfaction over extended periods of time needs to be established.

The fact that dropouts reported marginal satisfaction/dissatisfaction with treatment, having only stayed for very brief periods of time (in this study a median of three sessions) suggests that client expectations of help were not only not met, but also not in line with the way psychotherapy works. Unlike the short-term/improved client, however, dropouts did not change for the better, as least as far as their therapists could tell, due to treatment placebos, work in the brief contact itself, or therapeutic environmental changes. The question of misaligned treatment expectations is, therefore, raised as a possible reason for the treatment dissatisfaction of dropouts as well as a possible reason for their early terminations. As with other former clients, dropouts did report terminating for a variety of reasons (treatment and therapist dissatisfaction being only two of the reasons mentioned), but misaligned expectations could lead clients to become disenchanted with treatment in such a way that external factors, such as time, money, and transportation, become more important than continuation in therapy.

It is important to note that although long-term/improved clients cornered the market on gain and satisfaction with psychotherapy, dropouts, as well as short-term/improved clients and long-term/unimproved clients, did not exclusively deny gain and benefit from treatment. Dropout reports, on the average, ranged from no impact to slightly helpful, from no benefit to some benefit, and from slight dissatisfaction to slight satisfaction. These minimally positive findings cast some doubt upon the notion, expressed by Kelner (1982), that there is no obvious positive results from treating psychotherapy dropouts. It may be that these small gains represent the potential for greater benefit, within the limitations of a brief treatment situation. Further exploration of the impact of brief unplanned treatment contact needs to be conducted to determine whether or not these results indicate the potential for real gain or are artifactual in nature.

The long-term/unimproved group. The long-term/unimproved group of clients tended to report therapy on the average as unhelpful and were dissatisfied with their treatments. Given their own reports of lack of treatment impact and dissatisfaction, as well as their therapists' reports of lack of clinical improvement, the question is raised as to why both client and therapist continued in an apparently unproductive process for relatively lengthy periods of time.

It seems possible that an important psychological process had taken place in these cases that was not consciously valued nor reported on by clients and their therapists, and therefore not measured by the

evaluation procedures used in this study. Another possibility is that clients and/or therapists continued the treatment process in the belief or hope that improvement would eventually take place given appropriate time and effort. It also seems possible, however, that client and therapist expectations about what psychotherapy could and should do for these clients were amiss. As such reality testing with regard to the clinical usefulness of continuation in therapy may not have been conducted by either client or therapist, and the client's ability to make an informed choice about when and/or why to terminate would therefore have been impeded.

The long-term/unimproved client's continuation in therapy despite an experience of therapy as unhelpful and unsatisfactory suggests a lack of integration about the treatment experience that supports the notion of uninformed choice. If this is true, the long-term/unimproved group of clients may represent a class of clients that deserves special attention as serious treatment failures.

Assumption: Dropouts Remain Clinically Unchanged And In Psychological Need Following Termination

The assumption that dropouts remain in psychological need following their terminations from treatment has been the cornerstone of professional concern for psychotherapy dropouts. The results of this study suggest that this concern, at least over the long run, is unwarranted.

With the exception of the variable Functioning Index, dropouts were not different from all other former psychotherapy clients on any of

the variables related to post-treatment functioning and well-being. Dropouts, as with other clients, reported on the average that they were getting along satisfactorily and that they changed for the better with regard to their presenting symptoms and problems. In addition, all former clients, dropouts included, reported on the average a feeling of slight need for further treatment at time of followup.

For the variable Functioning Index (a composite of two variables that measured overall sense of well-being plus degree of overall change as a result of therapy), dropouts scored less well than other former clients as a group. Dropouts cannot be targeted as unique in terms of this general measure of level of functioning, however, because kind of outcome (improved/unimproved) was found to account for a significant portion of the variance on this variable, with unimproved clients scoring less well than improved clients.

The finding that dropouts reported satisfactory levels of functioning and well-being at followup supports the results of two other dropout studies (Garfield, 1963; Straker, et al., 1967) that showed dropout improvement and well-being at followup. These findings are also in line with the spontaneous remission and psychotherapy outcome control literatures that showed no-treatment and/or minimal contact clients as improved symptomatically and in other ways over time (e.g., Lambert, 1976; Malan, 1976a, 1976b; Sloane, et al., 1975; Voth & Orth, 1973)

It is important to note that despite the finding that dropouts reported satisfactory levels of functioning and well-being at followup,

and did not differ from other former psychotherapy clients in this regard, the process of change experienced by these clients was not measured and therefore cannot be evaluated on the basis of these data. This is a critical point for, as discussed by Gottman and Markman (1978), the value of an intervention should be judged by comparing it to other methods in terms of the immediacy, intensity, and stability of their respective effect patterns. For example, one wonders whether or not the improvement and sense of well-being reported at followup by long-term/improved clients was achieved as quickly, safely, easily, and economically as the improvement and sense of well-being reported at followup by psychotherapy dropouts. The broad question here is: Does the process of change with psychotherapy equal, quantitatively and qualitatively, the process of change without psychotherapy? The results of this study do not address this important scientific and quality of life question.

What can be addressed on the basis of these findings is that mental health professionals, in classifying short-term clients as psychotherapy dropouts, have inaccurately and unfairly targeted the short-term/unimproved client (not to mention the short-term/improved client) as a class of clients that requires special attention and handling with regard to long-term psychological well-being. Inasmuch as the term dropout is used to imply a state of psychological need and/or lack of improvement post-termination, professionals should consider discontinuing its use to avoid disseminating misleading and inaccurate information, especially considering the impact of the term at clinical, administrative, and government levels.

Before closing this section, it is interesting to note that in the set of analyses comparing the four length of stay/outcome groups to each other, it was found that the long-term/unimproved group of clients differed frequently from the other three groups (dropouts, short-term/improved clients, and long-term/improved clients) yet the other groups did not differ frequently from each other. The direction of these differences indicated that long-term/unimproved clients were functioning less well at followup and had less improvement in their presenting symptoms and problems. These findings support the notion, presented in a previous section, that long-term/unimproved clients represent a group of clients that deserve serious attention as real treatment failures. As such, they may warrant the professional attention and concern that has heretofore been reserved for short-term clients labelled psychotherapy dropouts.

Summary

The findings of this study are directly contrary to professional lore about the psychotherapy dropout being lost to treatment forever and remaining in psychological need, at least over the long run, following termination from treatment. As with other former therapy clients, dropouts reported on the average that they were getting along satisfactorily in a number of general and specific areas at time of followup, with definite improvement in their presenting symptoms and problems. Furthermore, some dropouts as with some other former clients went on for treatment elsewhere and reported terminating for reasons other than treatment or therapist dissatisfaction.

The finding that dropouts reported less help from therapy and less treatment satisfaction than all other former clients as a group provides some support for the professional assumption that dropouts gain nothing from brief contact. This support is limited for several reasons, however: (1) A qualitative analysis of the data revealed that dropout reports ranged on the average from no treatment effect to slight positive effect, and from slight dissatisfaction to slight satisfaction. As such, it cannot be concluded that dropouts receive nothing from treatment, only less than others as a group. (2) An in depth analysis of the treatment impact variables revealed that client reports of less treatment impact were significantly related to either negative outcomes and at times shorter stays in treatment. As such, dropout status per se (that is, a negative outcome plus a short length of stay) does not uniquely identify clients who fail to benefit from treatment. (3) For three of the treatment impact variables, including the variable of treatment satisfaction, long-term/improved clients were found to report distinctly higher levels of satisfaction and treatment helpfulness than all other specific groups of clients (the dropout group, the short-term/improved group, and the long-term/unimproved group), yet these other specific groups did not differ from each other. (4) In the set of analyses comparing the four length of stay/outcome groups to each other, the long-term/improved group of clients were found to differ frequently from the other three groups of clients, yet these other three groups did not differ frequently from each other. The direction of these differences

indicated that long-term/improved clients reported more gain from and satisfaction with treatment. These two latter sets of findings indicate that dropouts are not unusual nor alone in their experience of therapy as less helpful and less satisfactory. These results also indicate that individual psychotherapy does not meet all the needs of all clients who enter it, although there are some clients -- specifically clients in the long-term/improved group -- for whom it seems particularly well suited.

A number of specific findings provide grounds for some interesting speculation about the phenomena of treatment dropout. The extent to which the mental health professional's negative interpretation of dropping out of treatment is related to unresolved personal feelings that professionals may have about working with these clients was raised as a topic for further exploration. It was also suggested that misaligned role expectations and/or unrealistic expectations of help from therapy may play a significant role in client reports of less treatment helpfulness, less satisfaction with therapy, and discontinuation of treatment.

General Conclusions And Recommendations

Three major conclusions can be drawn from the results of this study about professional use of the term psychotherapy dropout: (1) Professionals need to clarify what they mean by the concept psychotherapy dropout; (2) Dropout incidence statistics, traditionally based upon a short length of stay criterion alone, should not be interpreted as direct indicators of total treatment failure; and (3) The usefulness of the term psychotherapy dropout is held in question, and professionals should consider discontinuing its use.

Conclusion 1. Professionals need to clarify what they mean by the concept psychotherapy dropout. Results indicated that the traditional short length of stay definition of dropout indiscriminately grouped short-term clients who were rated as clinically improved at termination by their therapists with short-term clients who were rated as clinically unimproved. To the extent that professional use of the term dropout is meant to imply lack of clinical gain at termination, these results support narrowing the operational definition of dropout to include only clients who have both short lengths of stay and negative outcomes at termination. On the other hand, client reports of treatment helpfulness and satisfaction indicated that the only group of clients to report distinct satisfaction with treatment and in some instances distinct gain from therapy was the long-term/improved group of clients. To the extent that professional use of the term dropout is meant to imply lack of clinical gain at termination only as a direct result of treatment, these results support broadening the operational definition of dropout to include not only all short-term therapy clients (short-term/improved and short-term/unimproved) but long-term/unimproved clients as well.

Clearly a distinction needs to be made in the conceptualization of the term dropout between clients who do not improve at all versus clients who do not gain as a direct result of treatment but improve nonetheless. As it stands now, the term implies both an absence of treatment effect, thereby generating administrative and economic concerns regarding use of limited professional and financial resources, as

well as a complete lack of clinical gain at termination, thereby generating concern for client welfare. Lack of clinical gain versus lack of treatment effect are two different concepts with two different operational definitions. In the interests of promoting clear communication about treatment dropout phenomena, mental health professionals need to clarify what they mean by the term dropout and make the appropriate revisions in their operational definitions in clinical practice and research.

Conclusion 2. Dropout incidence statistics, traditionally based upon a short length of stay criterion alone, should not be interpreted as direct indicators of total treatment failure. The validity of the mental health professional's blanket assumption of treatment failure with psychotherapy dropouts was tested using a two-criterion definition of dropout that implied, from the therapist's point of view, a complete lack of clinical gain at termination. In contrast to traditional assumption, results showed that dropouts did not unanimously reject treatment as a means to solve problems, and did report getting along satisfactorily at followup with definite improvement in their presenting symptoms and problems. Furthermore, while therapists' viewed dropouts as clinically unchanged (which includes lack of treatment effect), dropouts did not report a total absence of treatment effect and satisfaction, only less effect and satisfaction.

These findings indicate that professional use of the term dropout, based upon a short-stay/negative outcome definition, should be specifi-

cally limited to implications of treatment effect, in contrast to implications of client rejection of therapist or treatment, or lack of clinical improvement and well-being post-termination. Whether or not the term has implications concerning the client's opinion of overall clinical gain at termination could not be determined from these data and requires further research. In addition, given that the short-term/improved clients in this study were not essentially different from the short-term/unimproved dropouts in their post-treatment clinical histories and functioning, nor in their reports of less treatment helpfulness and satisfaction, it is concluded that incidence statistics on dropouts, generally based upon a short length of stay criterion alone, should not be interpreted at clinical, administrative, or government levels as direct indicators of total treatment failure. They may be interpreted, however, as indicators of less effect and satisfaction as compared to clients classified as conventional long-term treatment successes.

Conclusion 3. The usefulness of the term dropout is held in question and professionals should consider discontinuing its use. Results of this study indicated that psychotherapy dropouts were not essentially different from other former psychotherapy clients in terms of reasons for termination, certain characteristics of treatment, post-termination treatment histories, or levels of functioning at followup. Furthermore, while dropouts reported therapy as less helpful and less satisfactory, they were not unique in this regard. Only clients who had lengthier stays in treatment and had positive outcomes at termination, as evalu-

ated by their therapists, were distinct as a group in their reports of higher levels of treatment helpfulness and satisfaction.

Given that the purpose of classification is to identify a class of members that are similar to each other while at the same time different from members of other classes, these results cast serious doubt upon the usefulness of the term psychotherapy dropout. As it stands, the term fallaciously leads professionals to assume a uniqueness and homogeneity among clients classified as dropouts in terms of reasons for termination, treatment effect, and post-termination functioning and history that does not appear to exist. This in turn leads professionals away from understanding the treatment experience of the short-term or short-term/unimproved client for the individualistic and probably multi-determined experience that it is. Mental health professionals should therefore consider discontinuing the practice of dropout classification as it leads to the dissemination of misinformation about these clients and blurs the individuality of their experience.

Limitations of the study. Limitations include a possible sampling bias in that clients in the followup sample had slightly more improved outcomes at termination than former clients with whom contact was not achieved. Furthermore, these results were not cross-validated, and replication is therefore needed before definitive conclusions can be drawn about use of the term dropout or about psychotherapy dropouts in outpatient populations in general. The reader is reminded that these results are limited to outpatient clinic clients in individual psychotherapy

with closing diagnoses in the DSM-II neurotic range. Whether or not these results would apply to a more disturbed clinic population is not known. Lastly, the inherent potential for bias in the self report method, in retrospective evaluation, and in the followup questionnaire method of assessment needs to be kept in mind when considering these findings.

Recommendations for future research. Recommendations include replication with other outpatient clinic populations in individual psychotherapy. A revision in the professional outcome measure is recommended in which therapist attributions of change due to therapy are discriminated from therapist evaluations of overall change. A revision in the client followup measure is also recommended in which client attributions of change due to therapy are discriminated from client ratings of their overall clinical improvement at termination. A prospective versus retrospective study is the methodological approach of choice. Investigation of the therapist's personal experience of treatment dropout, particularly as it relates to understanding the mental health professional's negative interpretation of psychotherapy dropout phenomena, is recommended. Finally, an in depth analysis of the outcomes of short-term therapy clients is recommended, from both client and therapist perspectives, in the interests of understanding what promise unplanned brief contact holds for these clients within the context of traditional individual psychotherapy.

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APPENDIX A

PSYCHOTHERAPY FOLLOWUP QUESTIONNAIRE

On the following pages there are three types of questions in which you are asked to indicate how you feel about your psychotherapy experience at the Katharine Wright Clinic from _____ to _____ with _____. There are also some questions on how you are getting along now.

One type of question has a series of numbered statements under them. You should read each of these statements and select the one which comes closest to describing your answer to that question. Then circle the number in front of your answer.

The second type of question has below it a series of lettered items or statements on the left-hand side of the page. For each lettered item, circle the number under that statement which best applies.

In the third type of question you are asked to describe briefly your experiences in your own words.

BE SURE TO ANSWER EACH QUESTION.

PLEASE ANSWER THE QUESTIONS ABOUT YOUR PSYCHOTHERAPY EXPERIENCE ONLY AS THEY APPLY TO YOUR PSYCHOTHERAPY AT KATHARINE WRIGHT CLINIC IN THE TIME PERIOD MENTIONED ABOVE.

Identification_____

Today's date_____

Psychotherapy Research Project, Katharine Wright Clinic, 923 West Wellington, Chicago, Illinois, 60657, 312/528-6053.

1. How well do you feel you are getting along, emotionally and psychologically, at this time? (Circle the answer that best applies.)

   1. very well; much the way I would like to.

   2. quite well; no important complaints.

   3. fairly well; have my ups and downs.

   4. so-so; manage to keep going with some effort.

   5. fairly poorly; life gets pretty tough for me at times.

   6. quite poorly; can barely manage to deal with things.

2. Overall, how do you feel you have changed as a result of your psychotherapy at Katharine Wright Clinic? (Circle the answer that best applies.)

   1. a great deal for the better.

   2. somewhat for the better.

   3. made no difference; therapy did not change me in any way.

   4. somewhat for the worse.

   5. a great deal for the worse.

3. Please describe what positive or negative changes you have experienced as a result of your psychotherapy at Katharine Wright Clinic. (Use space provided on back of questionnaire if needed.)

WHY DID YOU ENTER THERAPY AT THE KATHARINE WRIGHT CLINIC? BRIEFLY DESCRIBE THE SYMPTOMS OR SPECIFIC PROBLEMS YOU WERE EXPERIENCING THAT LED YOU TO SEEK THERAPY.

4. Symptom/Problem A:_____

_____

5. Symptom/Problem B:_____

_____

6. Symptom/Problem C:_____

_____

7. Symptom/Problem D:_____

_____

HOW MUCH WERE EACH OF THE PROBLEMS OR SYMPTOMS YOU LISTED ABOVE TROUBLING TO YOU AT THE TIME YOU BEGAN THERAPY AT THE KATHARINE WRIGHT CLINIC? (Circle the answer that best applies.)

	Slightly Troubled Me	Moderately Troubled Me	Troubled Me Alot
8. Symptom/Problem A:	2	3	4
9. Symptom/Problem B:	2	3	4
10. Symptom/Problem C:	2	3	4
11. Symptom/Problem D:	2	3	4

HOW MUCH ARE EACH OF THESE SYMPTOMS OR PROBLEMS YOU LISTED ABOVE TROUBLING TO YOU AT THE PRESENT TIME? (Circle the answer that best applies.)

		Not A Problem For Me	Slightly Troubles Me	Moderately Troubles Me	Troubles Me Alot
12.	Symptom/ Problem A:	1	2	3	4
13.	Symptom/ Problem B:	1	2	3	4
14.	Symptom/ Problem C:	1	2	3	4
15.	Symptom/ Problem D:	1	2	3	4

IN WHAT WAY DID YOUR THERAPY AT KATHARINE WRIGHT CLINIC HELP OR NOT HELP YOU WITH EACH OF THESE PROBLEMS OR SYMPTOMS? (Circle the answer that best applies.)

		Made It Much Better	Made It A Little Better	Made No Difference	Made It A Little Worse	Made It Much Worse
16.	Symptom/ Problem A:	1	2	3	4	5
17.	Symptom/ Problem B:	1	2	3	4	5
18.	Symptom/ Problem C:	1	2	3	4	5
19.	Symptom/ Problem D:	1	2	3	4	5

BRIEFLY DESCRIBE WHAT PROBLEM AREAS YOU WORKED ON IN YOUR THERAPY AT KATHARINE WRIGHT CLINIC. THESE MAY OR MAY NOT BE THE SAME PROBLEMS THAT LED YOU TO SEEK THERAPY.

20. Problem Area A: _____

_____

21. Problem Area B: _____

_____

22. Problem Area C: _____

_____

23. Problem Area D: _____

_____

HOW WOULD YOU RATE YOUR ABILITY TO DEAL WITH THESE PROBLEM AREAS WHEN YOU BEGAN THERAPY AT KATHARINE WRIGHT CLINIC? (Circle the answer that best applies.)

	Slight Difficulty	Moderate Difficulty	Great Difficulty
24. Problem Area A:	2	3	4
25. Problem Area B:	2	3	4
26. Problem Area C:	2	3	4
27. Problem Area D:	2	3	4

HOW WOULD YOU RATE YOUR ABILITY TO DEAL WITH THESE PROBLEM AREAS AT THE PRESENT TIME? (Circle the answer that best applies.)

	No Difficulty	Slight Difficulty	Moderate Difficulty	Great Difficulty
28. Problem Area A:	1	2	3	4
29. Problem Area B:	1	2	3	4
30. Problem Area C:	1	2	3	4
31. Problem Area D:	1	2	3	4

IN WHAT WAY DID YOUR THERAPY AT KATHARINE WRIGHT CLINIC HELP OR NOT HELP YOU TO DEAL WITH EACH OF THESE PROBLEM AREAS?

	Made It Much Better	Made It A Little Better	Made No Difference	Made It A Little Worse	Made It Much Worse
32. Problem Area A:	1	2	3	4	5
33. Problem Area B:	1	2	3	4	5
34. Problem Area C:	1	2	3	4	5
35. Problem Area D:	1	2	3	4	5

36. Do you feel ill at ease or uncomfortable with other people now? (Circle the answer that best applies.)

    1. not at all.

    2. occasionally.

    3. often.

    4. all the time.

37. Since terminating therapy at Katharine Wright Clinic, what kind of an effect would you say therapy had on your relationships with other people?

    1. therapy greatly improved my relationships.

    2. therapy somewhat improved my relationships.

    3. therapy made no difference.

    4. therapy somewhat worsened my relationships.

    5. therapy greatly worsened my relationships.

38. Circle the answer which best applies:

    1. Prior to treatment I did <u>not</u> feel uncomfortable or ill at ease with other people.

    2. Prior to treatment I <u>did</u> feel uncomfortable or ill at ease with other people.

39. How much do you feel your therapy at Katharine Wright Clinic has or has not helped you to cope with <u>new</u> problems or symptoms that have arisen?

1. helped me to cope much better.
2. helped me to cope a little better.
3. made no difference.
4. made it a little harder to cope.
5. made it much harder to cope.

40. Why did you stop therapy? (Please circle only one answer.)

1. my decision.
2. my therapist's decision.
3. mutual agreement between myself and my therapist.
4. external factors (for example, moving away).

Please explain briefly in your own words the reason that therapy was terminated.

41. Since terminating therapy at Katharine Wright Clinic, have you ever felt a need for further treatment to deal with your problems?

    1. never.
    2. very rarely; once or twice.
    3. several times.
    4. quite often.
    5. all the time.

42. If you have felt a need for further treatment and did not seek it, briefly describe your reasons for not reentering treatment.

43. Have you consulted a physician, psychiatrist, psychologist, social worker, clergy, or anyone else in connection with emotional problems since terminating your therapy at Katharine Wright Clinic?

    1. no
    2. yes (If yes, please fill out the section below.)

	Dates (month/year) From	To	Number of Sessions per Month	Number of Months in Treatment
44. Outpatient Services	1._____/_____		_____	_____
	2._____/_____		_____	_____
	3._____/_____		_____	_____
	___If more than three, check here.			
45. Inpatient Services	1._____/_____		_____	_____
	2._____/_____		_____	_____
	3._____/_____		_____	_____
	___If more than three, check here.			

46. If you reentered therapy, was it for the same problems that led you to seek therapy at Katharine Wright Clinic?

    1. yes, the same problems.

    2. no, different problems.

    3. some of the same problems and some different problems.

    Briefly describe the nature of the problems.

47. At the present time, how much to you feel you need further therapy to deal with your problems?

    1. no need.

    2. slight need.

    3. definitely could use more.

    4. currently in therapy.

48. Everything considered, how satisfied are you with the results of your therapy experience at Katharine Wright Clinic?

    1. extremely satisfied.

    2. moderately satisfied.

    3. slightly satisfied.

    4. slightly dissatisfied.

    5. moderately dissatisfied.

    6. extremely dissatisfied.

I. HOW DO YOU FEEL ABOUT THE WAY YOU RELATE TO EACH OF THE PEOPLE LISTED BELOW?

(Circle the number under that statement which best describes how satisfied you are with the way you relate. Circle "0", under Does Not Apply, only when no such person exists.
For example, circle "0", if you have no children.

		Very Satisfied With Myself	Somewhat Satisfied With Myself	Somewhat Dissatisfied With Myself	Very Dissatisfied With Myself	Does Not Apply
1.	Mother	1	2	3	4	0
2.	Father	1	2	3	4	0
3.	Brothers/ Sisters	1	2	3	4	0
4.	Other Family Members	1	2	3	4	0
5.	Boss/Teacher	1	2	3	4	0
6.	Friends of same sex	1	2	3	4	0
7.	Friends of opposite sex	1	2	3	4	0
8.	Spouse	1	2	3	4	0
9.	Boyfriend/ Girlfriend	1	2	3	4	0
10.	Your children	1	2	3	4	0

II. LISTED BELOW ARE A NUMBER OF DIFFERENT JOBS OR ROLES THAT PEOPLE HAVE IN LIFE. IN EACH ONE WE PERFORM DIFFERENT TASKS AND HAVE DIFFERENT RESPONSIBILITIES. HOW DO YOU FEEL YOU HAVE BEEN PERFORMING IN THESE AREAS OF YOUR LIFE?

(Circle the number under that statement which best describes how you feel you have been performing. Circle "0", under Does Not Apply, only when you have no such role. For example, circle "0" if you are not a parent.)

		Very Well	Fairly Well	So-So	Quite Poorly	Does Not Apply
11.	As a parent	1	2	3	4	0
12.	As a wife/husband	1	2	3	4	0
13.	As a girlfriend/ boyfriend	1	2	3	4	0
14.	In work/career/ education	1	2	3	4	0
15.	As a homemaker (household responsi- bilities and chores)	1	2	3	4	0
16.	As a community/church member	1	2	3	4	0
17.	As a friend with same sex	1	2	3	4	0
18.	As a friend with opposite sex	1	2	3	4	0
19.	As a daughter/son	1	2	3	4	0

III. IN WHAT WAY HAS YOUR THERAPY EXPERIENCE AT KATHARINE WRIGHT CLINIC MADE A DIFFERENCE IN THE WAY YOU RELATE TO THE FOLLOWING PEOPLE IN YOUR LIFE?

(Circle the number under that statement which best applies for each person(s) listed below. Circle "0", under Does Not Apply, only when no such person exists.)

		Made It Much Better	Made It A Little Better	Made No Difference	Made It A Little Worse	Made It Much Worse	Does Not Apply
20.	Mother	1	2	3	4	5	0
21.	Father	1	2	3	4	5	0
22.	Brothers/ Sisters	1	2	3	4	5	0
23.	Other Family Members	1	2	3	4	5	0
24.	Boss/Teacher	1	2	3	4	5	0
25.	Friends of same sex	1	2	3	4	5	0
26.	Friends of opposite sex	1	2	3	4	5	0
27.	Spouse	1	2	3	4	5	0
28.	Boyfriend/ Girlfriend	1	2	3	4	5	0
29.	Your children	1	2	3	4	5	0

IV. IN WHAT WAY HAS YOUR THERAPY AT KATHARINE WRIGHT CLINIC MADE A DIFFERENCE IN THE WAY YOU PERFORM IN THE FOLLOWING AREAS?

(Circle the number under that statement which best applies for each of the areas listed below. Circle "0", under Does Not Apply, only if you have no such role.)

		Made It Much Better	Made It A Little Better	Made No Difference	Made It A Little Worse	Made It Much Worse	Does Not Apply
30.	As a parent	1	2	3	4	5	0
31.	As a wife/husband	1	2	3	4	5	0
32.	As a girlfriend/ boyfriend	1	2	3	4	5	0
33.	In work/career/ education	1	2	3	4	5	0
34.	As a homemaker (household responsibilities and chores)	1	2	3	4	5	0
35.	As a community/ church member	1	2	3	4	5	0
36.	As a friend with same sex	1	2	3	4	5	0
37.	As a friend with opposite sex	1	2	3	4	5	0
38.	As a daughter/son	1	2	3	4	5	0

V. WHAT DID YOU GET OUT OF YOUR THERAPY AT KATHARINE WRIGHT CLINIC?

(Please read each statement below and circle the number to the right of each statement that best applies.)

		None	Some	A Lot
39.	I got relief from unpleasant feelings or tensions.	1	2	3
40.	I got a deeper understanding of the reasons behind my feelings and behavior.	1	2	3
41.	I got confidence to try new things, to be a different kind of person.	1	2	3
42.	I learned what my feelings were and what I really wanted.	1	2	3
43.	I learned better self-control over my moods and actions.	1	2	3
44.	I worked out a particular problem that was bothering me.	1	2	3
45.	I felt better about myself as a person.	1	2	3
46.	I got relief from bodily aches and pains (headaches, back pain, etc.).	1	2	3
47.	If you have any other strong feelings about what you got or should have gotten out of therapy, please write in below:			
	_____	1	2	3
	_____	1	2	3

VI. EVERYBODY EXPERIENCES A NUMBER OF STRESSFUL EVENTS THROUGHOUT LIFE. LIST AND BRIEFLY DESCRIBE THREE IMPORTANT STRESSFUL EVENTS THAT YOU HAVE EXPERIENCED SINCE TERMINATING TREATMENT AT KATHARINE WRIGHT CLINIC. (Examples, losing your job, getting a job promotion, getting married, getting divorced, becoming seriously ill, death in the family.)

Event A: _____

_____

Event B: _____

_____

Event C: _____

_____

HOW WOULD YOU SAY THAT YOUR PAST THERAPY HAS OR HAS NOT HELPED YOU TO DEAL WITH THESE STRESSFUL EVENTS AS THEY CAME UP?

(Circle the number under that statement which best applies.)

		Helped A Great Deal	Helped A Little	Made No Difference	Made It A Little Difficult	Made It Very Difficult
48.	Event A:	1	2	3	4	5
49.	Event B:	1	2	3	4	5
50.	Event C:	1	2	3	4	5

51. How did you feel about your therapist as a person? (Circle the answer that best applies.)

    1. liked my therapist very much.
    2. liked my therapist some.
    3. disliked my therapist some.
    4. disliked my therapist very much.

52. How did your therapist feel about you as a person?

    1. my therapist liked me very much.
    2. my therapist liked me some.
    3. my therapist disliked me some.
    4. my therapist disliked me very much.

53. In your own words, describe what you found most valuable about your therapy at Katharine Wright Clinic.

54. In your own words, describe what you found most unhelpful about your therapy at Katharine Wright Clinic.

55. How confident are you in the accuracy of the responses you have made in this questionnaire?

    1. fairly confident.

    2. not confident in answers to many items. (Please briefly describe reasons below.)

56. Please use the space below for any further comments you would like to make about your therapy experience at Katharine Wright Clinic.

Having completed the questionnaire, if you have any further thoughts about changes you have experienced as a result of your psychotherapy, please return to page 3, item number 3, and include those changes.

APPENDIX B

Patient Code_____

Therapist Code_____

OUTCOME RATINGS OF THERAPIST CLOSING NOTES

1. Patient's condition at closing:

   (1) Considerably worse _____

   (2) Moderately worse _____

   (3) Slightly worse _____

   (4) No change _____

   (5) Slightly improved _____

   (6) Moderately improved _____

   (7) Considerably improved _____

2. Prognosis: further treatment needed:

   (1) Yes _____

   (2) Suspected _____

   (3) No _____

3. Disposition or Referral Recommendation:

   (1) Therapist terminated with referral _____

   (2) Patient withdrew from therapy _____

   (3) Therapist terminated without referral _____

4. Degree to which patient achieved understanding of problem or insight:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Little or none						Maximally	Insufficient Data

5. Degree to which patient achieved relief from emotional distress:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Little or none						Maximally	Insufficient Data

6. Degree of patient's personal integration:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Highly disorganized or defensively organized					Optimally integrated		Insufficient Data

7. Quality of patient's interpersonal relationships:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Unrealistic, immature inappropriate patterns of relationships					Realistic, mature, age-appropriate patterns of relationships		Insufficient Data

8. Estimate of therapist's feelings toward patient:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Strong dislike						Strong liking or respect	Insufficient Data

9. Therapist's outcome rating: patient's condition at closing and prognosis copied from the Therapist Closing Form:

	Further care needed	Further care suspected	No further care
Unimproved	____ (1)	____ (2)	____ (3)
Improved	____ (4)	____ (5)	____ (6)
Recovered	____ (7)	____ (8)	____ (9)

EVALUATION OF SYMPTOM CHANGE FROM TREATMENT SUMMARIES

Diagnosis:

Symptoms (assessed at intake):

A.

B.

C.

D.

E.

Specific Problems to be Changed (assessed at initial stages of therapy):

A.

B.

C.

D.

E.

Changes (assessed at termination of treatment):

A.

B.

C.

D.

E.

Rating of Problem Change at Closing:

	A	B	C	D	E
(1) Considerably worse	____	____	____	____	____
(2) Moderately worse	____	____	____	____	____
(3) Slightly worse	____	____	____	____	____
(4) No change	____	____	____	____	____
(5) Slightly improved	____	____	____	____	____
(6) Moderately improved	____	____	____	____	____
(7) Considerably improved	____	____	____	____	____

Additional Comments:

APPENDIX C

CLIENT FOLLOWUP LETTER

(This letter was sent to clients who were not contacted by telephone. It was produced on Katharine Wright Clinic stationery and mailed to the last known address listed in the client's chart.)

February, 1979

The Katharine Wright Clinic is asking people to participate in an evaluation of its services in an effort to provide better and more effective care. We would appreciate your comments on your experiences in psychotherapy, the benefits or lack of benefits you feel you received and your overall satisfaction with the care provided.

Enclosed is a reply card on which we would like you to indicate whether or not you will help us evaluate our services by filling out a simple questionnaire and self-evaluation form. The information which you provide us will be kept confidential, will be used for evaluation of our services only, and will not become part of your record at the clinic. If you would like to participate, please check the box "yes, I will participate" and indicate in the space below your current mailing address and phone number. Even if you do not wish to participate, please check the appropriate box and return the card in the enclosed, stamped self-addressed envelope. If you have any questions, please feel free to call Dr. Robert Yufit at (312) 528-6053.

Thank you for your cooperation

Psychotherapy Research Project
Katharine Wright Clinic

Enclosure

CLIENT FOLLOWUP POSTCARD

(This card was enclosed with the preceding letter.)

___Yes, I will participate
___I do not wish to participate

_____
Name

_____
Street Address

_____
City State Zip____

_____
Phone

_____

QUESTIONNAIRE COVER LETTER

(This cover letter was sent, along with the followup questionnaire and other followup materials, to clients who agreed to participate in the followup project. It was produced on Katharine Wright Clinic stationery.)

February, 1979

Thank you for agreeing to participate in the evaluation of our service to you. Enclosed are the materials which were mentioned during our telephone conversation.

On the following pages, there are questions in which you are asked things about yourself such as age, marital status, etc. that may help us to determine if there are general characteristics of people that are related to the experience of psychotherapy. There is also a questionnaire concerning your psychotherapy experience at the Katharine Wright clinic, how much you feel it has or has not helped you in your daily living, and some questions on how you are getting along now. Finally, there is a standardized questionnaire in which you are asked to rate yourself on certain complaints or problems that people sometimes have.

For you scheduling convenience, we estimate that it will take approximately 30-45 minutes to complete the enclosed forms. The information which you provide us will be kept confidential, will be used for evaluation of our services only, and will not become part of your record at the Katharine Wright Clinic. All information will be analyzed by computer using code numbers. Please do not include your name on the materials you return to us.

Please try to return the completed materials within three days in the enclosed self-addressed stamped envelope. If you have any questions, please feel free to call Dr. Robert Yufit at (312) 528-6053. Thank you for your participation.

Sincerely,

Psychotherapy Research Project
Katharine Wright Clinic

Enclosures

THERAPIST FOLLOWUP LETTER

(This cover letter was sent to all therapists whose clients qualified for inclusion in the psychotherapy followup sample. It was produced on Katharine Wright Clinic stationery.)

June 19, 1979

The Katharine Wright Clinic is conducting a psychotherapy followup study to evaluate the short- and long-term effectiveness of psychotherapy. Among the variables to be studied, therapist background characteristics will be looked at for their predictive value of therapeutic outcome.

The sample we are studying is comprised of patients seen between January 1973 and June 1978 and some of the cases you carried during this time are included. As such, we would appreciate your completing the enclosed Therapist Background Information form. The information you provide us will be treated confidentially and anonymously, and all will be analyzed as group data.

As we are interested in the time frame of January 1973 through June 1978, please complete the form as it applies to this time only. For example, if your therapeutic orientation has changed since June, 1978, specify only the orientation for the period in question. Further, if any change occured between January 1973 and June 1978, specify your new status and the month and year of the change. For example, under marital status if you went from single to married between January 1973 and June 1978, specify your new status (married) and the month and year this change took place.

We would greatly appreciate your participation and prompt reply as we are nearing the close of the data collection phase of the project. A stamped, self-addressed envelope is enclosed for your convenience. If you would like to receive information on the results of this study, please indicate this on the Therapist Background Information form.

Thank you for your cooperation.

Sincerely,

Psychotherapy Research Project
Katharine Wright Clinic

Enclosure

APPENDIX D

Patient Code_____

Therapist Code_____

PATIENT CHARACTERISTICS AND TREATMENT VARIABLES

1 Sex:

1____male
2____female

2 Marital Status:

1_____single
2_____engaged
3_____first marriage
4_____remarried
5_____separated
6_____divorced
7_____widowed

3 Number of children:

_____

4 Religious background:

1_____Protestant
2_____Roman Catholic
3_____Jewish
4_____Other
5_____None
6_____Mixed

5 Education:

1_____7th grade or less
2_____completed 8th grade
3_____some high school
4_____completed high school
5_____some college
6_____completed college
7_____graduate school (at least 1 year of professional training or graduate school)

12 Race:

1____White
2____Black
3____Hispanic
4____Oriental
5____Other (specify)

_____

13 Referral source:

1_____self-referred
2_____immediate family member
3_____close friend
4_____religious
5_____physician
6_____institutional support system (hospital, social service agency)
7_____private therapist

14 Student status:

1_____full-time student
2_____part-time student
3_____no

15 Employment status (at intake):

1_____employed full-time
2_____employed part-time
3_____unemployed

16,17, 18,19, 20 If employed, gross annual income at intake:

$_____

21 What is patient's job?

_____

6,7 Age: (Birthdate_____)
_____years (at intake)

8,9 Therapist age:_____years

10,11 Therapist experience:
_____years

28 Method of payment:

1_____private/self-paid
2_____partial insurance coverage
3_____Public Aid

29,30 Patient fee per session:
$_____

31,32 Total fee per session:
$_____

33,34,Waiting list information:

35,36
Date of initial patient contact _____
Date of orientation conference _____
Date of diagnostic evaluation _____
Date of first treatment session _____

37 Previous treatment:

Previous outpatient psychotherapy or formal counseling:

1_____yes
2_____no

38,39, 40,41 If yes, specify:

Date	Age	Length of Rx(mos)
_____	___	_____
_____	___	_____
_____	___	_____

22,23, 24,25, 26,27 If married, what is patient's spouse's job and gross annual income?

_____

$_____

Family background:

47 Number of older brothers____

48 Number of older sisters ____

49 Number of younger brothers__

50 Number of younger sisters___

51 Marital status of patient's parents:

1_____living together
2_____separated
3_____divorced
4_____one parent widowed
5_____both deceased

52 If parental home was broken while patient was growing up (by separation, divorce, or death), how old was patient at the time when this first happened?

1_____less than 5 years old
2_____6-10 years old
3_____11-15 years old
4_____16+ years old
5_____parental home not broken

53 What is (or was) occupation of patient's father?

_____

42 Inpatient treatment?

1_____yes
2_____no

43,44, 45,46 If yes, specify:

Date	Age	Length of Rx(mos)
_____	___	_____
_____	___	_____
_____	___	_____

57 How big is patient's "home town" (the place where patient grew up)?

1_____large city (over (1,000,000)
2_____city (under 1,000,000)
3_____suburb
4_____town
5_____rural

58 Where was patient born?

1_____United States
2_____Other (specify)
_____

59,60 How long patient has lived in United States--
____years

61 How fluent is patient's English--
1_____good
2_____fair
3_____poor

62 What is patient's native tongue?
_____

54 Is there a reported incidence of psychiatric problems in patient's family?
1_____yes
2_____no

If yes, specify:

	Fa.	Mo.	Sib.	Grand Par.
psychosis	1	5	9	13
alcoholism	2	6	10	14
drug abuse	3	7	11	15
neurosis	4	8	12	16

66 Diagnosis at Intake:

1_____Depressive neurosis
2_____Anxiety neurosis
3_____Hysterical neurosis
4_____Obsessive-Compulsive neurosis
5_____Personality Pattern Disturbance
6_____Schizophrenic (includes Schizoid Personality)
7_____Other (specify)
_____

67 Final Diagnosis:

1_____Depressive neurosis
2_____Anxiety neurosis
3_____Hysterical neurosis
4_____Obsessive-Compulsive neurosis
7_____Other (specify)
_____

68 Type of treatment recommended:

1_____supportive
2_____supportive + medication
3_____insight-oriented
4_____other (specify)
_____

63 Were there any existing medical problems before starting therapy as indicated in psychiatric evaluation?

1_____yes(specify)_____
2_____no

64 Prior to beginning treatment, did patient take any medication for anxiety?

1_____yes
2_____no

65 Was medication regularly administered during this treatment period?

1_____antidepressant
_____
2_____tranquilizer
_____
3_____no

69 Frequency of contact recommended:

1_____twice a week or more
2_____once a week
3_____twice a month
4_____once a month

Length of treatment:

Date of first treatment session:_____

Date of termination:
_____

70,71, 72 ____ of sessions scheduled

73,74 ____ of sessions cancelled

75,76 ____ of sessions failed

77,78, 79 ____ of sessions attended

Therapist Code_____

THERAPIST BACKGROUND INFORMATION

(for the period January 1973 through June 1978)

Professional (1/73-6/78; while at KWC):

1_____Psychiatrist
2_____Psychologist
3_____Psychiatric Social Worker
4_____Psychiatric Resident
5_____Psychology Intern
6_____Social Work Intern

Month and year beginning internship/residency:

_____

Therapeutic Orientation (while at KWC):

1_____psychoanalytic
2_____client-centered
3_____eclectic
4_____behavior modification
5_____other (specify)
_____

What major theorist(s) influenced your practice (while at KWC):

1_____Freud
2_____Sullivan
3_____Jung
4_____Adler
5_____Rogers
6_____Gestalt school
7_____Learning theorists

Marital Status (while at KWC):

1_____single
2_____engaged
3_____first marriage
4_____remarried
5_____separated
6_____divorced
7_____widowed

If change in marital status occurred while at KWC (between 1/73 and 6/78), please specify month and year of change and new status:

1_____single
2_____engaged
3_____first marriage
4_____remarried _____
5_____separated month and year
6_____divorced
7_____widowed

How many children did you have while at KWC: (if none, write "0")

_____

Please list month and year of birth of children born while at KWC between 1/73 and 6/78:

_____

Had you had personal therapy (while at KWC):

1_____yes (initiated prior to 1/73)
2_____yes (initiated during 1/73 and 6/78; specify month and year)
3_____no

Birthdate:_____

Sex: 1_____male
2_____female

What is (or was) the occupation of the primary financial provider in your household when you were growing up?

_____

What is (or was) the educational background of the above person?

7_____6th grade or less
6_____7th, 8th or 9th grade
5_____10th or 11th grade
4_____completed high school
3_____completed at least one full year of college
2_____college graduate
1_____completed at least one full year of graduate school

Do you speak another language fluently?

1_____yes (specify_____)
2_____no

How many older brothers? _____

How many older sisters? _____

How many younger brothers?____

How many younger sisters?_____

Religious Background:

1_____Protestant
2_____Roman Catholic
3_____Jewish
4_____Other
5_____None

Racial Background:

1_____White
2_____Black
3_____Hispanic
4_____Oriental
5_____Other (specify)

_____

How big is your home town (the place where you grew up)?

1_____large city (over 1,000,000)
2_____city (under 1,000,000)
3_____suburb
4_____town
5_____rural

____Check here if you would like information on the results of the Psychotherapy Followup Project.

APPENDIX E

ARRANGEMENT OF QUESTIONNAIRE ITEMS

ACCORDING TO PROFESSIONAL ASSUMPTION

CHARACTERISTICS OF TREATMENT

1. How much were each of the problems or symptoms you listed above troubling to you at the time you began therapy at Katharine Wright Clinic (Symptom/Problem A, Symptom/Problem B, Symptom/Problem C, Symptom/Problem D, as identified by client)? (Range: 2-4; Slightly Troubled Me to Troubled Me Alot; questionnaire item numbers: 8, 9, 10, 11.)

2. How would you rate your ability to deal with these problem areas (Problem Area A, Problem Area B, Problem Area C, Problem Area D, identified by client as worked on in therapy) when you began therapy at Katharine Wright Clinic? (Range: 2-4; Slight Difficulty to Great Difficulty; questionnaire item numbers: 24, 25, 26, 27.)

3. Prior to treatment did you or did you not feel uncomfortable or ill at ease with other people? (Range: 1-2; Felt Uncomfortable to Felt Comfortable; questionnaire item number: 38.)

4. How did you feel about your therapist as a person? (Range 1-4; Liked Very Much to Disliked Very Much; questionnaire item number: 51.)

5. How did your therapist feel about you as a person? (Range 1-4; Liked Very Much to Disliked Very Much; questionnaire item number: 52.)

"DROPOUTS ARE LOST TO TREATMENT FOREVER"

6. Why did you stop therapy (My decision; My therapist's decision; Mutual agreement between myself and my therapist; External factors)? (Range 1-2; Yes or No; questionnaire item number: 40a.)

7. Please explain in your own words the reason that therapy was terminated. (questionnaire item number: 40b.)

8. Since terminating therapy at Katharine Wright Clinic, have you ever felt a need for further treatment to deal with your problems? (Range: 1-5; Never to All The Time; questionnaire item number: 41.)

9. If you have felt a need for further treatment and did not seek it, briefly describe your reasons for not reentering treatment. (questionnaire item number: 42.)

10. Have you consulted a physician, psychiatrist, psychologist, social worker, clergy, or anyone else in connection with emotional problems since terminating your therapy at Katharine Wright Clinic? (Range: 1-2; No or Yes; questionnaire item number: 43.)

11. If you reentered therapy, was it for the same problems that led you to seek therapy at Katharine Wright Clinic? (Range: 1-3; Yes, The Same Problems to Some Same And Some Different to No, Different Problems; questionnaire item number: 46.)

12. At the present time, how much do you feel you need further therapy to deal with your problems? (Range: 1-4; No Need to Currently In Therapy; questionnaire item number: 47.)

"DROPOUTS GAIN NOTHING FROM THEIR BRIEF TREATMENT CONTACTS"

13. Overall, how do you feel you have changed as a result of your psychotherapy at Katharine Wright Clinic? (Range: 1-5; A Great Deal For The Better to A Great Deal For The Worse; questionnaire item number: 2.)

14. Please describe what positive or negative changes you have experienced as a result of your psychotherapy at Katharine Wright Clinic. (Range: 1-3; Positive to Equivocal to Negative Change; questionnaire item number: 3.)

15. In what way did your therapy at Katharine Wright Clinic help or not help you with each of these problems or symptoms (as identified by client: Symptom/Problem A; Symptom/Problem B; Symptom/Problem C; Symptom/Problem D)? (Range: 1-5; Made It Much Better to No Difference to Made It Much Worse; questionnaire item numbers: 16, 17, 18, 19/)

16. In what way did your therapy at Katharine Wright Clinic help or not help you to deal with each of these problem areas (problem areas worked on in therapy that were identified by client: Problem Area A; Problem Area B; Problem Area C; Problem Area D)? (Range: 1-5; Made It Much Better to No Difference to Made It Much Worse; questionnaire item numbers: 32, 33, 34, 35.)

17. Since terminating therapy at Katharine Wright Clinic, what kind of an effect would you say therapy had on your relationships with other people? (Range: 1-5; Greatly Improved to No Difference to Greatly Worsened; questionnaire item number: 37.)

18. How much do you feel your therapy at Katharine Wright Clinic has or has not helped you to cope with new problems or symptoms that have arisen? (Range: 1-5; Much Better to No Difference to Much Harder; questionnaire item number: 39.)

19. Everything considered, how satisfied are you with the results of your therapy experience at Katharine Wright Clinic? (Range: 1-6; Extremely Satisfied to Extremely Dissatisfied; questionnaire item number: 48.)

20. In what way has your therapy experience at Katharine Wright Clinic made a difference in the way you relate to the following people in your life: mother, father, brothers/sisters, other family members, boss/teacher, friends of same sex, friends of opposite sex, spouse, boyfriend/girlfriend, your children? (Range 1-5; Made It Much Better to No Difference to Made It Much Worse; questionnaire item numbers: III. 20-29.)

21. In what way has your therapy at Katharine Wright Clinic made a difference in the way you perform in the following areas: parent, wife/husband, girlfriend/boyfriend, work/career/education, homemaker, community/church member, friend with same sex, friend with opposite sex, daughter/son? (Range: 1-5; Made It Much Better to No Difference to Made It Much Worse; questionnaire item numbers: IV. 30-38.)

22. What did you get out of your therapy at Katharine Wright Clinic (relief from unpleasant feelings or tensions; deeper understanding of the reasons behind your feelings and behavior, confidence to try new things, to be a different kind of person; learned what your feelings were and what you really wanted, learned better self-control over your moods and actions, worked out a particular problem that was bothering you, felt better about self as a person, got relief from bodily aches and pains)? (Range: 1-3; None to Some to Alot; questionnaire item numbers: V. 39-47.)

23. How would you say that your past therapy has or has not helped you to deal with these stressful events as they came up (Event A, Event B, Event C, as identified by client)? (Range: 1-5; Helped A Great Deal to No Difference to Made It Very Difficult; questionnaire item numbers: VI. 48-50.)

"DROPOUTS REMAIN CLINICALLY UNCHANGED AND IN PSYCHOLOGICAL NEED FOLLOWING TERMINATION"

24. How well do you feel you are getting along, emotionally and psychologically, at this time? (Range: 1-6; Very Well to Quite Poorly; questionnaire item number: 1.)

25. How much are each of these symptoms or problems you listed above troubling to you at the present time (Symptom/Problem A, Symptom/Problem B, Symptom/Problem C, Symptom/Problem D, as identified by client)? (Range 1-4; Not A Problem For Me to Troubles Me Alot; questionnaire item numbers: 12, 13, 14, 15.)

26. How would you rate your ability to deal with these problem areas at the present time (Problem Area A, Problem Area B, Problem Area C, Problem Area D, as identified by client)? (Range: 1-4; No Difficulty to Great Difficulty; questionnaire item numbers: 28, 29, 30, 31.)

27. Symptom/Problem change score from entry to present for Symptom/Problem A, Symptom/Problem B, Symptom/Problem C, and Symptom/Problem D. (Range: +2 to -3; +2 = worse, 0 = no change, -3 = better.)

28. Problem Area change score from entry to present for Problem Area A, Problem Area B, Problem Area C, Problem Area D. (Range: +2 to -3; +2 = worse, 0 = no change, -3 = better.)

29. Do you feel ill at ease or uncomfortable with other people now? (Range: 1-4; Not At All to All The Time; questionnaire item number: 36.)

30. At the present time, how much do you feel you need further therapy to deal with your problems? (Range: 1-4; No Need to Currently In Therapy; questionnaire item number: 47.)

31. How do you feel about the way you relate to each of the people listed below (mother, father, brothers/sisters, other family members, boss/teacher, friends of same sex, friends of opposite sex, spouse, boyfriend/girlfriend, your children)? (Range: 1-4; Very Satisfied to Very Dissatisfied; questionnaire item numbers: I. 1-10.)

32. Listed below are a number of different jobs or roles that people have in life. In each one we perform different tasks and have different responsibilities. How do you feel you have been performing in these areas of your life (parent, wife/husband, girlfriend/boyfriend, work/career/education, homemaker, community/church member, friend with same sex, friend with opposite sex, daughter/son)? (Range: 1-4; Very Well to Quite Poorly; questionnaire item numbers: II. 11-19.)

33. Since terminating therapy at Katharine Wright Clinic, have you ever felt a need for further treatment to deal with your problems? (Range: 1-5; Never to All The Time; questionnaire item number: 41.)

34. Have you consulted a physician, psychiatrist, psychologist, social worker, clergy, or anyone else in connection with emotional problems since terminating your therapy at Katharine Wright Clinic? (Range: 1-2; No or Yes; questionnaire item number: 43.)

35. At the present time, how much do you feel you need further therapy to deal with your problems? (Range: 1-4; No Need to Currently In Therapy; questionnaire item number: 47.)

36. Combination of items 13 and 24: Functioning Index. (Range: 2-11; Very Well + Great Deal For The Better to Quite Poorly + Great Deal For The Worse.)

APPENDIX F

ONE-WAY ANOVAS COMPARING THE FOUR LENGTH OF STAY/OUTCOME GROUPS ON CHARACTERISTICS OF TREATMENT

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
How much were each of the problems or symptoms you listed above troubling to you at the time you began therapy at KWC?								
Symptom/Problem A	3.93	3.80	3.57	3.97	5.12	3,59	.003	ShortIMP< ShortUNIMP; ShortIMP< LongIMP
Symptom/Problem B	3.83	3.50	3.75	3.70	.41	3,47	.747	
Symptom/Problem C	3.75	4.00	3.57	3.62	.48	3,35	.697	
Symptom/Problem D	3.75	4.00	3.50	3.64	.35	3,20	.787	
How would you rate your ability to deal with these problems when you began therapy at KWC?								
Problem Area A	3.50	3.75	3.50	3.62	.22	3,53	.883	
Problem Area B	3.33	3.33	3.17	3.63	1.30	3,38	.287	
Problem Area C	3.60	3.00	2.67	3.67	2.41	3,26	.089	
Problem Area D	3.75	3.00	2.50	3.67	3.60	3,15	.039	ShortIMP< ShortUNIMP; ShortIMP< LongIMP

CHARACTERISTICS OF TREATMENT -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
Prior to treatment did you or did you not feel uncomfortable or ill at ease with other people?	1.54	1.80	1.57	1.71	.67	3,59	.574	
How did you feel about your therapist as a person?	2.36	2.00	2.07	1.60	1.95	3,59	.131	
How did your therapist feel about you as a person?	2.00	2.00	1.70	1.36	2.97	3,44	.042	None at .05

[a]The higher the mean score, the greater the degree of discomfort, difficulty, or disliking. For ranges and values of specific questions, see Appendix E.

ONE-WAY ANOVAS COMPARING THE FOUR LENGTH OF STAY/OUTCOME GROUPS ON THE ASSUMPTION "DROPOUTS ARE LOST TO TREATMENT FOREVER"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
Why did you stop therapy?								
My decision	1.79	1.50	1.43	1.27	3.96	3,58	.012	LongIMP< ShortUNIMP
My therapist's decision	1.00	1.25	1.07	1.17	1.21	3,58	.316	
Mutual decision	1.14	1.00	1.29	1.47	2.43	3,58	.075	
External factors	1.07	1.25	1.21	1.10	.67	3,58	.576	
Have you consulted a physician, psychiatrist, psychologist, social worker, clergy, or anyone else in connection with emotional problems since terminating your therapy at KWC?	1.50	1.60	1.43	1.45	.17	3,60	.919	
If you reentered therapy, was it for the same problems that led you to seek therapy at KWC?	1.43	1.00	1.67	1.67	.62	3,23	.607	
Since terminating your therapy at KWC have you ever felt a need for further treatment to deal with your problems?	3.07	3.75	2.54	2.87	1.24	3,58	.304	

"DROPOUTS ARE LOST..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
At the present time, how much do you feel you need further therapy to deal with your problems?	2.00	2.20	1.93	2.10	.12	3,60	.946	

[a]With the exception of two questions ("Why did you stop therapy?" and "If you reentered therapy...?", the higher the mean score, the greater the degree of psychological discomfort or need. For ranges and values of specific questions, see Appendix E.

ONE-WAY ANOVAS COMPARING THE FOUR LENGTH OF STAY/OUTCOME GROUPS ON THE ASSUMPTION "DROPOUTS GAIN NOTHING FROM THEIR BRIEF TREATMENT CONTACTS"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
Overall, how do you feel you have changed as a result of your psycho-therapy at KWC?	2.50	2.40	2.36	1.74	4.77	3,60	.005	LongIMP< ShortUNIMP
In what way did your therapy at KWC help or not help you to deal with each of these problems?								
Symptom/Problem A	2.38	2.20	2.14	1.53	4.36	3,58	.008	LongIMP< ShortUNIMP
Symptom/Problem B	2.18	2.50	2.00	1.41	5.28	3,46	.003	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP
Symptom/Problem C	2.71	2.67	2.86	1.57	5.86	3,34	.003	LongIMP< ShortIMP; LongIMP< ShortUNIMP
Symptom/Problem D	3.00	3.00	2.00	1.71	3.09	3,19	.052	None at .05
In what way did your therapy at KWC help or not help you to deal with each of these problem areas?								
Problem Area A	2.33	2.00	2.17	1.66	1.99	3,53	.126	
Problem Area B	2.11	2.33	2.20	1.79	.65	3,37	.590	

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
In what way did ...? (continued)								
Problem Area C	2.40	3.00	3.00	1.48	3.76	3,25	.024	LongIMP< ShortIMP
Problem Area D	2.50	3.00	2.00	1.50	2.63	3,14	.091	
Please describe what positive and negative changes you have experienced as a result of your psycho-therapy at KWC?	1.75	1.60	1.42	1.32	1.20	3,53	.318	
Since terminating therapy at KWC, what kind of effect would you say therapy had on your relationships with other people?	2.64	2.40	2.14	1.77	5.00	3,60	.004	LongIMP< ShortUNIMP
In what way has your therapy experience made a difference in the way you relate to to following people in your life?								
Mother	2.77	2.80	2.31	2.08	2.87	3,51	.045	None at .05
Father	2.91	2.33	2.57	2.33	1.83	3,35	.159	
Brothers/sisters	2.71	2.50	2.38	2.18	1.44	3,55	.241	
Other family members	2.69	3.00	2.73	2.20	2.81	3,49	.049	None at .05

"DROPOUTS GAIN NOTHING..." -- Continued"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
In what way ...? (continued)								
Boss/teacher	2.75	3.00	2.50	1.93	4.44	3,53	.007	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP
Friends of same sex	2.86	2.40	2.69	1.90	7.80	3,59	.000	LongIMP< ShortUNIMP; LongIMP< ShortIMP
Friends of opposite sex	2.86	2.80	2.57	2.23	3.38	3,60	.024	LongIMP< ShortUNIMP
Spouse	2.63	3.00	2.50	1.60	2.45	3,21	.092	
Boyfriend/girlfriend	2.78	2.50	2.13	2.06	1.69	3,35	.188	
Your children	2.50	3.00	2.33	1.60	3.47	3,17	.040	LongIMP< ShortUNIMP; LongIMP< LongUNIMP
In what way has your therapy at KWC made a difference in the way you perform in the following areas?								
Parent	2.00	3.00	2.33	1.60	2.28	3,16	.118	
Wife/husband	2.43	3.00	2.44	2.00	1.01	3,23	.407	
Girlfriend/boyfriend	2.88	2.75	2.43	1.81	4.28	3,31	.012	LongIMP< ShortUNIMP; LongIMP< LongUNIMP

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
In what way ...? (continued)								
Work/career education	2.77	2.75	2.62	1.80	8.54	3,56	.000	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP
Homemaker	2.69	2.75	3.00	2.37	3.25	3,56	.028	LongIMP> ShortIMP
Community/church member	2.88	3.00	2.80	2.62	.71	3,40	.551	
Friend with same sex	2.85	2.60	2.69	1.97	6.04	3,58	.001	LongIMP< ShortUNIMP; LongIMP< ShortIMP
Friend with opposite sex	2.83	2.80	2.64	2.13	3.77	3,58	.015	LongIMP< ShortUNIMP
Daughter/son	2.77	2.80	2.58	2.14	2.41	3,48	.079	
How much do you feel your therapy at KWC has or has not helped you to cope with new symptoms or problems that have arisen?	2.43	2.40	2.50	1.71	5.17	3,60	.003	LongIMP< ShortUNIMP; LongIMP< ShortIMP

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
How would you say that your therapy has or has not helped you to deal with these stresful events as they came up?								
Event A	2.67	2.75	2.29	1.73	4.45	3,56	.007	LongIMP< ShortUNIMP; LongIMP< LongUNIMP
Event B	2.75	3.00	2.50	1.83	6.43	3,53	.001	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP
Event C	2.56	3.00	2.45	1.86	2.93	3,40	.045	None at .05
What did you get out of your therapy at KWC?								
Relief from unpleasant feelings or tensions.	2.21	2.40	1.92	1.48	4.66	3,57	.006	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
Deeper understanding of the reasons behind my feelings and behavior.	2.21	2.40	2.00	1.58	3.75	3,59	.016	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP
Confidence to try new things, to be a different kind of person.	2.71	2.80	2.08	1.44	8.07	3,59	.000	LongIMP< ShortUNIMP; LongIMP< LongUNIMP
Learned what my feelings were and what I really wanted.	2.57	2.20	2.23	1.94	2.77	3,59	.049	LongIMP< ShortUNIMP
Learned better self-control over my moods and actions.	2.50	2.40	2.46	1.80	5.92	3,58	.001	LongIMP< ShortUNIMP; LongIMP< ShortIMP
Worked out a particular problem that was bothering me.	2.50	2.60	2.00	1.63	5.35	3,58	.003	LongIMP< ShortUNIMP; LongIMP< LongUNIMP

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
What did you get ...? (continued)								
Felt better about myself as a person.	2.57	2.60	1.68	2.08	9.77	3,59	.000	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP
Got relief from bodily aches and pains.	2.79	2.40	2.73	2.41	1.05	3,55	.376	
Everything considered, how satisfied are you with the results of your therapy at KWC?	3.50	3.80	3.21	1.81	5.56	3,60	.002	LongIMP< ShortUNIMP; LongIMP< LongUNIMP; LongIMP< ShortIMP

[a]The higher the mean score, the greater the dissatisfaction or lack of positive change. Mean scores for categories under the question "What did you get out of your therapy at KWC?" have been reflected to provide continuity in direction of value within the table. For ranges and values of specific questions, see Appendix E.

ONE-WAY ANOVAS COMPARING THE FOUR LENGTH OF STAY/OUTCOME GROUPS ON THE ASSUMPTION "DROPOUTS REMAIN CLINICALLY UNCHANGED AND IN PSYCHOLOGICAL NEED FOLLOWING TERMINATION"

Followup Question	Means [a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
Functioning Index: Getting along now + Changed as a result of therapy.	5.64	5.60	4.64	4.35	3.42	3,60	.023	LongIMP< ShortUNIMP
How well do you feel you are getting along, emotionally and psychologically, at this time?	3.14	3.20	2.29	2.61	1.93	3,60	.134	
How much are each of these symptoms or problems troubling to you at the present time?								
Symptom/Problem A	1.92	2.60	1.21	1.77	4.10	3,58	.011	ShortIMP< ShortUNIMP; ShortIMP< LongUNIMP; ShortIMP< LongIMP; LongIMP< LongUNIMP
Symptom/Problem B	2.00	2.75	1.63	1.85	2.04	3,47	.121	
Symptom/Problem C	2.29	3.33	2.14	1.52	4.58	3,34	.009	LongIMP< LongUNIMP
Symptom/Problem D	2.33	4.00	1.75	1.86	3.64	3,19	.032	ShortIMP< LongUNIMP; LongIMP< LongUNIMP

"DROPOUTS REMAIN CLINICALLY UNCHANGED..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
How would you rate your ability to deal with these problem areas at the present time?								
Problem Area A	2.17	2.25	1.42	1.72	2.32	3,53	.086	
Problem Area B	1.89	2.67	1.50	1.75	1.57	3,38	.212	
Problem Area C	1.60	3.00	2.33	2.00	.66	3,26	.582	
Problem Area D	2.00	3.00	1.00	1.75	1.42	3,15	.276	
At the present time, how much do you feel you need further therapy to deal with your problems?	2.00	2.20	1.93	2.10	.12	3,60	.946	
Do you feel ill at ease or uncomfortable with other people now?	1.93	2.60	1.93	1.97	1.64	3,60	.189	
How do you feel about the way you relate to each of the people listed below?								
Mother	2.15	2.60	1.79	1.74	1.57	3,51	.209	
Father	2.00	2.00	1.75	2.11	.31	3,35	.819	
Brothers/sisters	1.86	1.75	1.50	1.71	.67	3,56	.574	
Other family members	2.00	2.50	1.45	1.73	1.99	3,50	.128	
Boss/teacher	1.73	2.50	1.75	1.66	1.28	3,52	.290	

"DROPOUTS REMAIN CLINICALLY UNCHANGED..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
How do you feel...? (continued)								
Friends of same sex	1.71	2.05	1.43	1.58	2.26	3,59	.091	
Friends of opposite sex	1.93	2.60	1.57	2.03	1.69	3,59	.179	
Spouse	2.14	3.00	1.63	1.50	2.46	3,20	.092	
Boyfriend/girlfriend	2.25	2.50	1.67	1.38	2.77	3,30	.059	
Your children	2.25	2.00	1.00	1.73	1.68	3,16	.211	
How do you feel you have been performing in these areas of your life?								
Parent	2.25	2.00	1.67	1.82	.36	3,16	.782	
Wife/husband	2.14	2.00	1.50	1.88	.68	3,20	.575	
Girlfriend/boyfriend	1.88	2.50	1.71	1.81	.94	3,31	.432	
Work/career/ education	2.15	2.75	1.43	1.81	2.89	3,58	.043	ShortIMP< LongUNIMP
Homemaker	2.23	2.75	1.86	2.13	1.28	3,57	.290	
Community/church member	2.75	2.80	2.80	2.52	.18	3,40	.913	
Friend with same sex	1.79	2.40	1.64	1.65	1.46	3,60	.235	
Friend with opposite sex	1.92	2.40	1.93	2.16	.49	3,58	.688	
Daughter/son	2.15	2.40	2.17	1.83	1.13	3,50	.344	

"DROPOUTS REMAIN CLINICALLY UNCHANGED..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	F	df	p	Direction
Symptom/Problem change score from entry to present:								
Symptom/Problem A	-2.00	-1.20	-2.36	-2.20	2.69	3,58	.054	LongUNIMP< ShortIMP; LongUNIMP< LongIMP
Symptom/Problem B	-1.83	-.75	-2.13	-1.85	2.28	3,47	.092	
Symptom/Problem C	-1.43	-.67	-1.43	-2.10	2.65	3,34	.064	
Symptom/Problem D	-1.33	-0.00	-1.75	-1.79	1.44	3,19	.261	
Problem Area change score from entry to present:								
Problem Area A	-1.33	-1.50	-2.09	-1.90	1.57	3,53	.208	
Problem Area B	-1.44	-.67	-1.67	-1.88	1.84	3,38	.156	
Problem Area C	-2.00	0.00	-.33	-1.67	2.80	3,26	.139	
Problem Area D	-1.75	0.00	-1.50	-1.92	1.45	3,15	.269	

[a]The higher the mean score, the greater the psychological discomfort, difficulty, dissatisfaction, or felt need for therapy. For ranges and values of specific questions, see Appendix E.

APPENDIX G

TWO-WAY ANOVAS OF LENGTH OF STAY AND OUTCOME ON CHARACTERISTICS OF TREATMENT

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
How much were each of the problems or symptoms you listed above troubling to you at the time you began therapy at KWC?								
Symptom/Problem A	3.93	3.80	3.57	3.97	LOS	7.93	1,59	.007
					OUT	2.72	1,59	.104
					LOSxOUT	7.03	1,59	.010
Symptom/Problem B	3.83	3.50	3.75	3.70	LOS	.61	1,47	.437
					OUT	.04	1,47	.843
					LOSxOUT	.17	1,47	.455
Symptom/Problem C	3.75	4.00	3.57	3.62	LOS	.25	1,35	.624
					OUT	1.26	1,35	.270
					LOSxOUT	.18	1,35	.673
Symptom/Problem D	3.75	4.00	3.50	3.64	LOS	.39	1,20	.539
					OUT	.97	1,20	.337
					LOSxOUT	.03	1,20	.863
How would you rate your ability to deal with these problem areas when you began therapy at KWC?								
Problem Area A	3.50	3.75	3.50	3.62	LOS	.57	1,53	.454
					OUT	.05	1,53	.833
					LOSxOUT	.04	1,53	.783
Problem Area B	3.33	3.33	3.17	3.63	LOS	1.99	1,38	.167
					OUT	.02	1,38	.904
					LOSxOUT	.93	1,38	.341
Problem Area C	3.60	3.00	2.67	3.67	LOS	3.22	1,26	.084
					OUT	1.08	1,26	.308
					LOSxOUT	4.00	1,26	.056

CHARACTERISTICS OF TREATMENT -- Continued

Followup Question	Means [a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
How would you rate ...? (continued)								
Problem Area D	3.75	3.00	2.50	3.67	LOS	2.99	1,15	.105
					OUT	1.88	1,15	.191
					LOSxOUT	7.67	1,15	.014
Prior to treatment did you or did you not feel uncomfortable or ill at ease with other people?	1.54	1.80	1.57	1.71	LOS	1.67	1,59	.202
					OUT	.01	1,59	.918
					LOSxOUT	.17	1,59	.681
How did you feel about your therapist as a person?	2.36	2.00	2.07	1.60	LOS	2.46	1,59	.122
					OUT	1.18	1,59	.283
					LOSxOUT	.04	1,59	.856
How did your therapist feel about you as a person?	2.00	2.00	1.70	1.36	LOS	1.47	1,44	.232
					OUT	3.96	1,44	.053
					LOSxOUT	.59	1,44	.455

[a]The higher the mean score, the greater the degree of discomfort, difficulty, or disliking. For ranges and values of specific questions, see Appendix E.

TWO-WAY ANOVAS OF LENGTH OF STAY AND OUTCOME ON THE ASSUMPTION "DROPOUTS ARE LOST TO TREATMENT FOREVER"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
Why did you stop therapy?								
My decision	1.79	1.50	1.43	1.27	LOS	2.15	1,58	.148
					OUT	4.81	1,58	.032
					LOSxOUT	.17	1,58	.686
My therapist's decision	1.00	1.25	1.07	1.17	LOS	2.23	1,58	.141
					OUT	.04	1,58	.842
					LOSxOUT	1.19	1,58	.281
Mutual decision	1.14	1.00	1.29	1.47	LOS	.63	1,58	.432
					OUT	3.21	1,58	.079
					LOSxOUT	1.73	1,58	.193
External factors	1.07	1.25	1.21	1.10	LOS	.20	1,58	.660
					OUT	.18	1,58	.672
					LOSxOUT	1.73	1,58	.193
Have you consulted a physician, psychiatrist, psychologist, social worker, clergy, or anyone else in connection with emotional problems since terminating your therapy at KWC?	1.50	1.60	1.43	1.45	LOS	.10	1,60	.754
					OUT	.44	1,60	.512
					LOSxOUT	.06	1,60	.807
If you reentered therapy, was it for the same problems that led you to seek therapy at KWC?	1.43	1.00	1.67	1.67	LOS	.16	1,23	.696
					OUT	1.45	1,23	.241
					LOSxOUT	.40	1,23	.531

"DROPOUTS ARE LOST TO TREATMENT FOREVER" -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
Since terminating your therapy at KWC, have you ever felt a need for further treatment to deal with your problems?	3.07	3.75	2.54	2.87	LOS	1.60	1,58	.210
					OUT	3.24	1,58	.077
					LOSxOUT	.21	1,58	.652
At the present time, how much do you feel you need further therapy to deal with your problems?	2.00	2.20	1.93	2.10	LOS	.37	1,60	.547
					OUT	.07	1,60	.793
					LOSxOUT	.00	1,60	.961

[a]With the exception of two questions ("Why did you stop therapy?" and "If you reentered therapy...?"), the higher the mean score, the greater the degree of psychological discomfort or need. For ranges and values of specific questions, see Appendix E.

TWO-WAY ANOVAS OF LENGTH OF STAY AND OUTCOME ON THE ASSUMPTION "DROPOUTS GAIN NOTHING FROM THEIR BRIEF TREATMENT CONTACTS"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
Overall, how do you feel you have changed as a result of your psychotherapy at KWC?	2.50	2.40	2.36	1.74	LOS	5.61	1,60	.021
					OUT	2.45	1,60	.123
					LOSxOUT	1.33	1,60	.253
In what way did your therapy at KWC help or not help you to deal with each of these problems?								
Symptom/Problem A	2.38	2.20	2.14	1.53	LOS	5.00	1,58	.029
					OUT	2.86	1,58	.096
					LOSxOUT	.74	1,58	.393
Symptom/Problem B	2.18	2.50	2.00	1.41	LOS	1.62	1,46	.210
					OUT	5.29	1,46	.026
					LOSxOUT	3.28	1,46	.077
Symptom/Problem C	2.71	2.67	2.86	1.57	LOS	8.32	1,34	.007
					OUT	1.20	1,34	.281
					LOSxOUT	3.00	1,34	.093
Symptom/Problem D	3.00	3.00	2.00	1.71	LOS	1.90	1,19	.184
					OUT	3.82	1,19	.065
					LOSxOUT	.73	1,19	.403
In what way did your therapy at KWC help or not help you to deal with each of these problem areas?								
Problem Area A	2.33	2.00	2.17	1.66	LOS	3.07	1,53	.086
					OUT	.67	1,53	.429
					LOSxOUT	.09	1,53	.769

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
In what way did ...? (continued)								
Problem Area B	2.11	2.33	2.20	1.79	LOS	.27	1,37	.606
					OUT	.28	1,37	.601
					LOSxOUT	.71	1,37	.406
Problem Area C	2.40	3.00	3.00	1.48	LOS	2.66	1,25	.116
					OUT	.20	1,25	.656
					LOSxOUT	3.50	1,25	.073
Problem Area D	2.50	3.00	2.00	1.50	LOS	.00	1,14	.951
					OUT	3.24	1,14	.094
					LOSxOUT	.75	1,14	.401
Please describe what positive and negative changes you have experienced as a result of your psychotherapy at KWC?	1.75	1.60	1.42	1.32	LOS	.32	1,53	.574
					OUT	2.14	1,53	.149
					LOSxOUT	.02	1,53	.899
Since terminating therapy at KWC, what kind of effect would you say therapy had on your relationships with other people?	2.64	2.40	2.14	1.77	LOS	2.83	1,60	.098
					OUT	6.46	1,60	.014
					LOSxOUT	.08	1,60	.778
In what way has your therapy experience made a difference in the way you relate to the following people in your life?								
Mother	2.77	2.80	2.31	2.08	LOS	.45	1,51	.504
					OUT	5.74	1,51	.020
					LOSxOUT	.28	1,51	.597

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
In what way has ...? (continued)								
Father	2.91	2.33	2.57	2.33	LOS	2.02	1,35	.164
					OUT	.70	1,35	.409
					LOSxOUT	.42	1,35	.522
Brothers/sisters	2.71	2.50	2.38	2.18	LOS	.82	1,55	.370
					OUT	1.72	1,55	.195
					LOSxOUT	.00	1,55	.988
Other family members	2.69	3.00	2.73	2.20	LOS	1.75	1,49	.192
					OUT	1.36	1,49	.250
					LOSxOUT	3.00	1,49	.090
Boss/teacher	2.75	3.00	2.50	1.93	LOS	2.19	1,53	.145
					OUT	4.39	1,53	.041
					LOSxOUT	2.24	1,53	.140
Friends of same sex	2.86	2.40	2.69	1.90	LOS	12.85	1,59	.001
					OUT	1.99	1,59	.164
					LOSxOUT	.60	1,59	.441
Friends of opposite sex	2.86	2.80	2.57	2.23	LOS	2.07	1,60	.156
					OUT	3.88	1,60	.054
					LOSxOUT	.49	1,60	.488
Spouse	2.63	3.00	2.50	1.60	LOS	2.36	1,21	.140
					OUT	.79	1,21	.385
					LOSxOUT	1.38	1,21	.253
Boyfriend/girlfriend	2.78	2.50	2.13	2.06	LOS	.23	1,35	.634
					OUT	3.41	1,35	.073
					LOSxOUT	.12	1,35	.736
Your children	2.50	3.00	2.33	1.60	LOS	.46	1,17	.505
					OUT	3.85	1,17	.066
					LOSxOUT	2.74	1,17	.116

"DROPOUTS GAIN NOTHING..." -- Continued"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
In what way has your therapy at KWC made a difference in the way you perform in the following areas?								
Parent	2.00	3.00	2.33	1.60	LOS	.03	1,16	.858
					OUT	1.45	1,16	.245
					LOSxOUT	4.68	1,16	.046
Wife/husband	2.43	3.00	2.44	2.00	LOS	.09	1,23	.762
					OUT	.94	1,23	.342
					LOSxOUT	1.86	1,23	.186
Girlfriend/boyfriend	2.88	2.75	2.43	1.81	LOS	2.57	1,31	.119
					OUT	5.48	1,31	.026
					LOSxOUT	.73	1,31	.401
Work/career/education	2.77	2.75	2.62	1.80	LOS	9.53	1,56	.003
					OUT	3.93	1,56	.052
					LOSxOUT	3.02	1,56	.088
Homemaker	2.69	2.75	3.00	2.37	LOS	6.37	1,56	.015
					OUT	.10	1,56	.748
					LOSxOUT	2.72	1,56	.105
Community/church member	2.88	3.00	2.80	2.62	LOS	.19	1,40	.668
					OUT	1.07	1,40	.307
					LOSxOUT	.51	1,40	.478
Friend with same sex	2.85	2.60	2.69	1.97	LOS	8.40	1,58	.005
					OUT	2.43	1,58	.125
					LOSxOUT	1.23	1,58	.294
Friend with opposite sex	2.83	2.80	2.64	2.13	LOS	3.64	1,58	.062
					OUT	2.93	1,58	.092
					LOSxOUT	1.11	1,58	.296
Daughter/son	2.77	2.80	2.58	2.14	LOS	1.66	1,48	.203
					OUT	2.43	1,48	.126
					LOSxOUT	.94	1,48	.336

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means [a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
How much do you feel your therapy at KWC has or has not helped you to cope with new symptoms or problems that have arisen?	2.43	2.40	2.50	1.71	LOS	7.79	1,60	.007
					OUT	.94	1,60	.336
					LOSxOUT	2.69	1,60	.106
How would you say that your therapy has or has not helped you to deal with these stressful events as they came up?								
Event A	2.67	2.75	2.29	1.73	LOS	2.67	1,56	.108
					OUT	4.87	1,56	.031
					LOSxOUT	1.23	1,56	.273
Event B	2.75	3.00	2.50	1.83	LOS	5.97	1,53	.018
					OUT	3.31	1,53	.075
					LOSxOUT	2.35	1,53	.132
Event C	2.56	3.00	2.45	1.86	LOS	2.27	1,40	.140
					OUT	1.54	1,40	.222
					LOSxOUT	2.25	1,40	.142
What did you get out of your therapy at KWC?								
Relief from unpleasant feelings or tensions.	2.21	2.40	1.92	1.48	LOS	1.62	1,57	.209
					OUT	6.01	1,57	.017
					LOSxOUT	1.96	1,57	.167
Deeper understanding of the reasons behind my feelings and behavior.	2.21	2.40	2.00	1.58	LOS	1.47	1,59	.230
					OUT	4.25	1,59	.044
					LOSxOUT	1.83	1,59	.182

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
What did you get ...? (continued)								
Confidence to try new things, to be a different kind of person.	2.71	2.80	2.08	1.44	LOS	1.22	1,59	.274
					OUT	14.68	1,59	.000
					LOSxOUT	.96	1,59	.331
Learned what my feelings were and what I really wanted.	2.57	2.20	2.23	1.94	LOS	2.68	1,59	.107
					OUT	2.22	1,59	.142
					LOSxOUT	.03	1,59	.859
Learned better self-control over my moods and actions.	2.50	2.40	2.46	1.80	LOS	8.11	1,58	.006
					OUT	1.85	1,58	.179
					LOSxOUT	2.11	1,58	.152
Worked out a particular problem that was bothering me.	2.50	2.60	2.00	1.63	LOS	1.18	1,58	.282
					OUT	8.82	1,58	.004
					LOSxOUT	.98	1,58	.326
Felt better about myself as a person.	2.57	2.60	1.68	2.08	LOS	4.26	1,59	.043
					OUT	12.52	1,59	.001
					LOSxOUT	1.97	1,59	.165
Got relief from bodily aches and pains.	2.79	2.40	2.73	2.41	LOS	2.36	1,55	.130
					OUT	.02	1,55	.901
					LOSxOUT	.02	1,55	.879

"DROPOUTS GAIN NOTHING..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
Everything considered, how satisfied are you with the results of your therapy at KWC?	3.50	3.80	3.21	1.81	LOS	4.50	1,60	.038
					OUT	3.82	1,60	.055
					LOSxOUT	7.78	1,60	.088

[a]The higher the mean score, the greater the dissatisfaction or lack of positive change. Mean scores for categories under the question "What did you get out of your therapy at KWC?" have been reflected to provide continuity in direction of value within the table. For ranges and values of specific questions, see Appendix E.

TWO-WAY ANOVAS OF LENGTH OF STAY AND OUTCOME ON THE ASSUMPTION "DROPOUTS REMAIN CLINICALLY UNCHANGED AND IN PSYCHOLOGICAL NEED FOLLOWING TERMINATION"

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
Functioning Index: Getting along now + Changed as a result of therapy.	5.64	5.60	4.64	4.35	LOS	.34	1,60	.563
					OUT	7.07	1,60	.010
					LOSxOUT	.08	1,60	.773
How well do you feel you are getting along emotionally and psychologically at this time?	3.14	3.20	2.29	2.61	LOS	.74	1,60	.392
					OUT	5.62	1,60	.021
					LOSxOUT	.17	1,60	.682
How much are each of these symptoms or problems troubling to you at the present time?								
Symptom/Problem A	1.92	2.60	1.21	1.77	LOS	4.53	1,58	.011
					OUT	9.69	1,58	.003
					LOSxOUT	.06	1,58	.804
Symptom/Problem B	2.00	2.75	1.63	1.85	LOS	2.44	1,47	.125
					OUT	4.92	1,47	.031
					LOSxOUT	.93	1,58	.341
Symptom/Problem C	2.29	3.33	2.14	1.52	LOS	.20	1,34	.662
					OUT	5.84	1,34	.021
					LOSxOUT	4.17	1,34	.026
Symptom/Problem D	2.33	4.00	1.75	1.86	LOS	1.59	1,19	.223
					OUT	8.18	1,19	.010
					LOSxOUT	2.65	1,19	.120

"DROPOUTS REMAIN CLINICALLY UNCHANGED..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
How would you rate your ability to deal with these problem areas at the present time?								
Problem Area A	2.17	2.25	1.42	1.72	LOS	1.14	1,53	.291
					OUT	6.78	1,53	.012
					LOSxOUT	.18	1,53	.675
Problem Area B	1.89	2.67	1.50	1.75	LOS	1.99	1,38	.166
					OUT	3.81	1,38	.059
					LOSxOUT	.69	1,38	.412
Problem Area C	1.60	3.00	2.33	2.00	LOS	.02	1,26	.881
					OUT	.06	1,26	.811
					LOSxOUT	1.77	1,26	.195
Problem Area D	2.00	3.00	1.00	1.75	LOS	2.53	1,15	.132
					OUT	4.01	1,15	.064
					LOSxOUT	.05	1,15	.826
At the present time, how much do you feel you need further therapy to deal with your problems?	2.00	2.20	1.93	2.10	LOS	.37	1,60	.547
					OUT	.07	1,60	.793
					LOSxOUT	.00	1,60	.961
Do you feel ill at ease or uncomfortable with other people now?	1.93	2.60	1.93	1.97	LOS	1.52	1,60	.222
					OUT	1.64	1,60	.206
					LOSxOUT	2.66	1,60	.108
How do you feel about the way you relate to each of people listed below?								
Mother	2.15	2.60	1.79	1.74	LOS	.14	1,51	.712
					OUT	3.90	1,51	.054
					LOSxOUT	.72	1,51	.399

"DROPOUTS REMAIN CLINICALLY UNCHANGED..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
How do you feel ...? (continued)								
Father	2.00	2.00	1.75	2.11	LOS	.65	1,35	.424
					OUT	.13	1,35	.726
					LOSxOUT	.27	1,35	.605
Brothers/sisters	1.86	1.75	1.50	1.71	LOS	.49	1,56	.488
					OUT	1.43	1,56	.237
					LOSxOUT	.53	1,56	.471
Other family members	2.00	2.50	1.45	1.73	LOS	1.90	1,50	.175
					OUT	5.66	1,50	.021
					LOSxOUT	.17	1,50	.684
Boss/teacher	1.73	2.50	1.75	1.66	LOS	.29	1,52	.595
					OUT	1.33	1,52	.254
					LOSxOUT	2.51	1,52	.119
Friends of same sex	1.71	2.05	1.43	1.58	LOS	2.16	1,59	.147
					OUT	4.71	1,59	.034
					LOSxOUT	1.70	1,59	.198
Friends of opposite sex	1.93	2.60	1.57	2.03	LOS	4.18	1,59	.045
					OUT	2.45	1,59	.123
					LOSxOUT	.14	1,59	.706
Spouse	2.14	3.00	1.63	1.50	LOS	.03	1,20	.866
					OUT	5.29	1,20	.032
					LOSxOUT	1.59	1,20	.222
Boyfriend/girlfriend	2.25	2.50	1.67	1.38	LOS	.07	1,30	.798
					OUT	6.02	1,30	.020
					LOSxOUT	.62	1,30	.438
Your children	2.25	2.00	1.00	1.73	LOS	.93	1,16	.350
					OUT	3.57	1,16	.077
					LOSxOUT	1.46	1,16	.245

"DROPOUTS REMAIN CLINICALLY UNCHANGED..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
How do you feel you have been performing in these areas of your life?								
Parent	2.25	2.00	1.67	1.82	LOS	.00	1,16	.988
					OUT	.73	1,16	.407
					LOSxOUT	.20	1,16	.662
Wife/husband	2.14	2.00	1.50	1.88	LOS	.49	1,20	.491
					OUT	1.73	1,20	.203
					LOSxOUT	.25	1,20	.626
Girlfriend/boyfriend	1.88	2.50	1.71	1.81	LOS	.96	1,31	.335
					OUT	1.78	1,31	.192
					LOSxOUT	.75	1,31	.393
Work/career/education	2.15	2.75	1.43	1.81	LOS	2.92	1,58	.093
					OUT	8.18	1,58	.006
					LOSxOUT	.14	1,58	.712
Homemaker	2.23	2.75	1.86	2.13	LOS	2.01	1,57	.162
					OUT	3.04	1,57	.087
					LOSxOUT	.19	1,57	.661
Community/church member	2.75	2.80	2.80	2.52	LOS	.21	1,40	.650
					OUT	.07	1,40	.799
					LOSxOUT	.16	1,40	.693
Friend with same sex	1.79	2.40	1.64	1.65	LOS	.66	1,60	.421
					OUT	2.67	1,60	.107
					LOSxOUT	1.67	1,60	.201
Friend with opposite sex	1.92	2.40	1.93	2.16	LOS	1.29	1,58	.261
					OUT	.09	1,58	.763
					LOSxOUT	.18	1,58	.676
Daughter/son	2.15	2.40	2.17	1.83	LOS	.46	1,50	.503
					OUT	.83	1,50	.368
					LOSxOUT	1.40	1,50	.243

"DROPOUTS REMAIN CLINICALLY UNCHANGED..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
Symptom/Problem change score from entry to present:								
Symptom/Problem A	-2.00	-1.20	-2.36	-2.20	LOS	2.19	1,58	.145
					OUT	6.07	1,58	.017
					LOSxOUT	1.62	1,58	.208
Symptom/Problem B	-1.83	- .75	-2.13	-1.85	LOS	3.40	1,47	.045
					OUT	4.24	1,47	.071
					LOSxOUT	1.70	1,47	.199
Symptom/Problem C	-1.43	- .67	-1.43	-2.10	LOS	.52	1,34	.474
					OUT	2.45	1,34	.127
					LOSxOUT	3.26	1,34	.080
Symptom/Problem D	-1.33	0.00	-1.75	-1.79	LOS	.38	1,19	.545
					OUT	3.14	1,19	.093
					LOSxOUT	1.20	1,19	.288
Problem Area change score from entry to present:								
Problem Area A	-1.33	-1.50	-2.09	-1.90	LOS	.12	1,53	.736
					OUT	4.09	1,53	.048
					LOSxOUT	.31	1,53	.580
Problem Area B	-1.44	- .67	-1.67	-1.88	LOS	.10	1,38	.756
					OUT	3.18	1,38	.083
					LOSxOUT	1.84	1,38	.184
Problem Area C	-2.00	0.00	- .33	-1.67	LOS	.72	1,26	.405
					OUT	.61	1,26	.441
					LOSxOUT	5.17	1,26	.031

"DROPOUTS REMAIN CLINICALLY UNCHANGED..." -- Continued

Followup Question	Means[a] Short UNIMP	Long UNIMP	Short IMP	Long IMP	Source	F	df	p
Problem Area change ... (continued)								
Problem Area D	-1.75	-0.00	-1.50	-1.92	LOS	.23	1,15	.638
					OUT	1.13	1,15	.305
					LOSxOUT	3.16	1,15	.096

[a]The higher the mean score, the greater the psychological discomfort, difficulty, dissatisfaction, or felt need for therapy. For ranges and values of specific questions, see Appendix E.

APPROVAL SHEET

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

11/6/85
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